Assessment Form: Asthma

Date: ______________________

Grade/Teacher: _____________

Easton Arts Academy
30 North 4th Street, Easton, Pennsylvania 18042
Phone (484) 546-4230 Fax (610) 829-6076

Dear parent/guardian of ____
According to our records, your student has a history of asthma or has shown symptoms of asthma. We would like to find out more about your student's current health status so that we can provide better care. Please complete the questionnaire below.
Please don't hesitate to reach out if you have any questions.

Sincerely,

School Nurse: Claire Wake RN, CSN Email: cwake@eaaecs.org

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Name of asthma physican: ___________________ Phone: __________________
May we contact the physician about your student's asthma? Yes/No
When was your student diagnosed with asthma? ___________________________
When was your student's last asthma attack? ______________________________
What triggers an asthma attack? (Circle any applicable)

Exercise Infections Food Environmental Factors
Animals Medications Seasonal Factors

Allergies (list): ____
Irritants (list): ____
What medications does your student take for asthma?
Medication: _________________ Dose: ________ Frequency: ______________
Medication: _________________ Dose: ________ Frequency: ______________
Use of a peak flow meter? Yes/No If so, what is the normal reading? ___________
Will your student require medication during the school day for their asthma?
YES____________ NO_____________

If YES please have your student's doctor complete the attached asthma action plan, return it to the school nurse, and arrange medication drop off.

What signs/symptoms occur during an asthma attack? _______________________
____
Last year, about how many days did you student miss school because of athsma? ____
How often does your student see the doctor each year because of asthma? _________
Has your student been hospitalized because of asthma? Yes/No
If so, when? __________________ How many times last year? _________
Has your student even been placed on a ventilator because of asthma? Yes/No
Please note additional comments on the back of this form. Thank you.

Parent/Guardian Signature: _________________________ Date: ___________

Asthma Action Plan for Home and School

Name ______________________ DOB ____/____/________

Severity Classification ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list) ______________________

Peak Flow Meter Personal Best _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Peak Flow Meter _____(more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	______	______	______	☐ Home ☐ School
	______	______	______	☐ Home ☐ School

Physical Activity ☐ Use albuterol/levalbuterol ____ puffs, 15 minutes before activity ☐ with all activity ☐ when the child feels he/she needs it

Yellow Zone: Caution

Symptoms: Some problems breathing – Cough, wheeze, or chest tight – Problems working or playing – Wake at night

Peak Flow Meter _____to _____(between 50% and 79% of personal best)

Quick-relief Medicine(s) ☐ Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) ☐ Continue Green Zone medicines

☐ Add ______________________ ☐ Change to ______________________

The child should feel better within 20–60 minutes of the quick-relief treatment. If the child is getting worse or is in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping

Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! ☐ Albuterol/levalbuterol ____ puffs, ______________________(how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms.
The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to "Take at School".

☐ **Both the Healthcare Provider and the Parent/Guardian** feel that the child has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Healthcare Provider

Name ______________ Date ________ Phone (____) ____-______ Signature ______________

Parent/Guardian

☐ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate.

☐ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.

Name ______________ Date ________ Phone (____) ____-______ Signature ______________

School Nurse

☐ The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.

Name ______________ Date ________ Phone (____) ____-______ Signature ______________

Please send a signed copy back to the provider listed above.

EASTON ARTS ACADEMY

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS PROCEDURE

Dear Parents/Guardians:

We urge parents to refrain from bringing prescription and over-the-counter (OTC) medications to school unless it is absolutely necessary during school hours. If unavoidable, we **MUST** have the proper Authorization For Medication During School Hours form completed and signed by both the parent/guardian and physician, or medication will not be given. The Pennsylvania Nurse Practice Act forbids the administration of medication by RNs and LPNs without direct authorization from a licensed physician. If your child must take medication at school, the procedure is as follows:

1. An Authorization For Medication During School Hours form is required from the family physician, which shall indicate the necessity of the medication(s) being given to the child during school hours, the name of the medication, the time it is to be given, the dose, and possible reaction(s), if any. This must be done for all prescription, over-the-counter (OTC) medications/remedies, herbal or homeopathic supplements, oils, and/or vitamins.
2. The Authorization For Medication During School Hours form and written statements from physicians are only good for one school year. If the dose or time of the medication changes during the school year, a new form will be required. Forms are available in the nurse's office.
3. Medication is to be brought to school by a parent/guardian in the original pharmacy container and delivered to the school nurse. The container must be labeled with the student's full name, name of physician, dosage of medication to be given, and time when it is to be given. If this procedure is not followed, the medication will not be given. **Do not send medication to school with your child. If your child brings medication to school, it will not be given.**
4. The first dose of any new medication will not be given in school for your child's safety. If this procedure is not followed, the medication will not be given.
5. Students are expected to come to the health room to take their medication at the required time.
6. **A nurse will not be attending any field trips.** If your child needs medical attention during a field trip, teachers and chaperones will care for the child and emergency services will be called if necessary. If any medications are needed during this time, please make arrangements for a parent/guardian to chaperone, so that they may administer the medication themselves.
7. All student medication remaining in the health room at the end of the school year must be picked up by the parent/guardian. If this procedure is not followed, any remaining medication will be discarded.

EASTON ARTS ACADEMY

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

To: School Nurse

Date: ______________________

My child, ______________________________________, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program. I will provide the medication in an appropriately labeled, original pharmacy container, as well as all over-the-counter (OTC) medication my physician has ordered.

Name of medication: ____

Prescribed dosage: ____

Time schedule: ____

Physician name (please print): ____

Physician telephone number: ____

List of side effects of medication: ____

Diagnosis and necessity of medication during school hours: ________________________

____

Expected duration of medication regime: ____

The student is excused from these activities while taking this medication:

Physical Education: ________________________ Other: ________________________

PHYSICIAN SIGNATURE: ____

As the parent/guardian, I do hereby release, discharge, and hold harmless, Easton Arts Academy and its agents and employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

PARENT/GUARDIAN SIGNATURE: ____

The student may carry his/her rescue **inhaler / Epi-Pen and has demonstrated that he/she can properly self-administer and accepts full responsibility for the administration of his/her emergency medication.

Prescriber/Physician: ________________________________ Date: ______________

Parent/Guardian: ________________________________ Date: ______________