East Helena Public Schools
School District No. 9
P.O. Box 1280 * East Helena, MT. 59635
Superintendent/Administration Office (406) 227-7700
Eastgate Elementary School (406) 227-7770 * Prickly Pear Elementary (406) 227-7720
Radley Elementary School (406) 227-7710 * East Valley Middle School (406) 227-7740
East Helena High School (406) 227-7700
"Success For All"
Eastgate Elementary Fax: 406-227-8479 * EVMS Fax: 406-227-9730
Radley Fax: 406-227-7713 * Prickly Pear fax: 406-227-3369

Asthma Health Assessment

The following assessment questions will help me to have more information regarding your son/daughter's health condition in order to provide the best care possible while your child is at school. Please answer the following questions, and include any other information you feel that we should know.

1. Has your child been admitted to the hospital or seen in the Emergency Room due to Asthma Symptoms?_____

2. What are the most common triggers for your childs Asthma?

   _____
   _____
   _____

3. Please list any current medications your child is taking

   _____
   _____
   _____

4. Will your child be riding the bus to or from school? _____

5. Please share any additional information that you feel may be helpful for me to know.

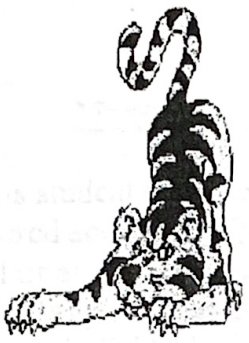
   _____
   _____
   _____
   _____

In case of an emergency it is very important that we are able to reach you. Please share your contact information.

Name _____

Phone (H)_____(C)_____
(W)_____

Email _____



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Asthma Medication Permission Form

Student's Name _____

School _____ Grade _____ Teacher_____

Diagnosis _____

Medication _____

Time _____ Dosage _____

Special instructions _____

Possible side affects _____

_____ _____

Physician's Signature/Date Parent's Signature/Date

_____ This student is capable of administering his/her inhaler appropriately and may carry it with him/her.

_____ This student's medication should be kept in the nurse's office.

_____ The Montana Student Asthma Action Plan has been completed and signed by both parent and physician.

_____If possible, please provide the school with a back-up inhaler to be kept in the medication lockup for emergencies.

Physician's signature _____

Parent's signature _____

Montana Asthma Action Plan

Montana Asthma Control Program
Chronic Disease Prevention & Health Promotion Bureau

Name_____ Age_____ Visiting nurse_____ Phone_____

Parent/guardian_____ Phone 1_____ Phone2_____

Healthcare provider_____ Phone_____Fax_____

Green Zone

Child is feeling well

- No difficulty participating in usual activities
- No chest tightness, shortness of breath, wheezing, or coughing during the day or night

Take these controller medications every day:

Name Dose When to take it

_____

_____

Before exercise: Medication _____Dosage _____ ____minutes prior to activity

Yellow Zone

Child is not feeling well

- Chest tightness, shortness of breath, wheezing, or coughing with usual activities
- Waking at night due to asthma symptoms

Continue taking controller medication(s) and add these quick-relief medications:

Name Dose When to take it

_____

_____

Call child's healthcare provider if: _____

_____

Red Zone

Alert! Contact child's healthcare provider or call 911 if:

- Quick-relief medication is not helping
- Breathing is hard and fast
- Ribs are showing and nostrils are flaring
- Can't walk or talk well

Take the following medications, and call the child's healthcare provider or 911 right away:

Medicine Dose When to Take it

_____

_____

Other key medical information

Child's asthma triggers, and other useful information:_____

_____

Reviewed by parent/guardian _____ Date_____

Reviewed by home visiting nurse _____ Date_____

Reviewed by child's healthcare provider _____ Date_____