



NOTE: Parents are to provide the physician’s medical management plan to the school *annually*. The medical orders, along with the health intake below, assist the school nurse in developing an Individual Healthcare Plan for the student.

Student’s Name: _____ DOB: ___/___/___ Grade: _____ Today’s Date: ___/___/___

Parent/Guardian 1: _____ Contact Information: _____

Parent/Guardian 2: _____ Contact Information: _____

Name of physician treating student’s asthma: _____ Phone Number: _____

Health Insurance: Private Medicaid/KanCare Currently without insurance

Medical alert jewelry worn? Yes No IEP? Yes No Current 504 Plan? Yes No

Mode of transportation to and from school? _____

Does student participate in before or after school activities? Yes No

Student’s age of onset of asthma symptoms? _____ Age at diagnosis of asthma? _____

What symptoms does student display during an asthma episode? (Please check all that apply):

- Wheezing Coughing Shortness of breath Chest tightness
- Other (Please list): _____

During the day, how often does student have a hard time with coughing, wheezing, or breathing?

- 2 times a week or less More than 2 times a week All the time, throughout the day, every day

During the night, how often does student wake up or have a hard time with coughing, wheezing, or breathing?

- 2 nights a month or less More than 2 nights a month
- More than 2 nights a week More than 4 nights a week

How much does student’s asthma bother or interrupt normal activities (playing, sports, running around)?

- Never Rarely Sometimes Often All of the time

How many times has student been to the emergency room or hospitalized for asthma in the past year?

- 0 times 1 time 2 times 3 times 4 times 5 or more times

How many days did student miss school last year for asthma symptoms (wheezing, coughing, shortness of breath?)

- 0 days 1-2 days 3-5 days 6-9 days 10-14 days 15 or more days

Does the student also have a life-threatening allergy or anaphylaxis? No Yes _____

What triggers the student’s asthma, or what makes symptoms worse? (Please check all that apply)

- Animals/Pets Changes in weather/cold or heat Dust/dust mites Smoke
- Stress/emotional upset Mold Grass/flowers Strong smells/perfumes Illness/colds
- Other (Please list): _____

Does the student use a peak flow meter? Yes No

If yes, what is his/her personal best peak flow number? _____



Does the student have an Asthma Action Plan (AAP), written by a healthcare provider? Yes No

If yes, has a copy of the AAP been brought to school? Yes No

Does anybody in the household smoke? Yes No

Please write the names or colors of medicines (inhalers/puffers, pills, liquids, nebulizers) the student takes for asthma and allergies (both every day and as-needed medicines)

Name of medication	Color of medication (Inhaler)	DAILY or AS NEEDED?

How well does the student take his/her asthma medications? (Check only one answer)

- Takes medicine by self
- Needs help taking medicine
- Not currently using medicine

Equipment and supplies provided by parent (indicate for each supply listed):

	Stays at school	Home to school each day
Daily Asthma Medications		
Peak Flow Meter		
Spacer for Metered Dose Inhaler		
Nebulizer/Tubing/Mask		

Does your student have family, peer, and community support systems? Yes No

Describe your student’s response and current coping/adaptation to having asthma: _____

Does your healthcare provider recommend your student self-carry and administer his/her own inhaler?

- Yes No

NOTE: Prior to self-carry/administration, the student’s ability must be assessed by the school nurse and other required paperwork received per school district medication policy (e.g. healthcare provider order, self-carry administration form).

Parent/Guardian Signature: _____ Date: _____