

**STUDENT ASTHMA INFORMATION**  
(Medically Confidential Material)

**PLEASE PRINT:**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_  
 Teacher Name: \_\_\_\_\_ School: \_\_\_\_\_

**ATTACH COPY OF STUDENT EMERGENCY CARD FOR ADDITIONAL INFORMATION**

**ASTHMA:** a disorder involving the respiratory system and air exchange.

**Describe your child's asthma episode** (e.g., rests, takes medicines, sees doctor, visits emergency room, is hospitalized):

\_\_\_\_\_

**How often does your child have an episode?** \_\_\_\_\_ x week \_\_\_\_\_ x month \_\_\_\_\_ x year

**What usually causes (triggers) an episode?** \_\_\_\_\_

\_\_\_\_\_

**What usually helps if an episode occurs?** \_\_\_\_\_

\_\_\_\_\_

**What is child's current personal best peak flow?** \_\_\_\_\_ **Date** \_\_\_\_\_

**How often does your child do peak flows?** \_\_\_\_\_

PEAK FLOW ZONES	TREATMENT PLAN
<b>GREEN ZONE</b> _____ to _____ Peak flow 80-100% of personal best	<b>Long-term Control - Daily Medications</b> Medication(s) ↑↑↑↑↑↑↑↑↑↑↑↑↑↑ Before Exercise ↑↑↑↑↑↑↑↑↑↑↑↑↑↑ See Daily Management Regimen below. <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs of _____ _____ minutes before exercise.
<b>YELLOW ZONE</b> _____ to _____ Peak flow 50-80% of personal best	<b>Quick Relief - For Mild/Moderate Symptoms</b> First, take this medicine ↑↑↑↑↑↑↑↑ <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs or <input type="checkbox"/> by nebulizer one time Then, If improvement in 15 minutes ↑↑↑ If <b>no</b> improvement in 15 minutes ↑
<b>RED ZONE</b> Below _____ Peak flow less than 50% of personal best	<b>ALERT - For Severe Symptoms</b> First, take this medicine ↑↑↑↑↑↑↑↑ <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs or <input type="checkbox"/> by nebulizer one time If feeling better or repeat peak flow is in yellow zone ↑↑↑↑↑↑↑↑↑↑↑↑↑↑ If <b>no</b> improvement <b>or</b> repeat peak flow is in red zone <b>or</b> nails or lips are blue <b>or</b> breathing is difficult ↑↑ <b>CALL 911!</b>

**Daily management regimen:**

MEDICATION	DOSAGE	TIME(S)	TAKEN AT SCHOOL	
1. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Side effects to any asthma medication(s): \_\_\_\_\_

**Medication:** The parent/guardian shall provide the school nurse with medication for this condition to be administered PRN (on an as needed basis).  Yes  No

**Additional medications:**

MEDICATION	DOSAGE	TIME(S)	TAKEN AT SCHOOL	
1. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. _____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Side effects to additional medication(s): \_\_\_\_\_

Does exercise affect your child's asthma?  Yes  No If **YES**, list types of exercise.

*NOTE: If your child is unable to participate in physical education activities for a period of longer than three (3) consecutive days as a result of this condition, a written excuse from your child's physician must be obtained.*

In which sports can your child fully participate? \_\_\_\_\_

Do certain weather conditions/seasons affect your child's asthma?  Yes  No If **YES**, please explain.

**Additional information/special instructions** (e.g., Are there any objects, items, or animals in the classroom environment that might aggravate your child's asthma?):

Special instructions from physician: \_\_\_\_\_

**Release of information:** The undersigned parent/guardian authorizes the release and/or exchange of medical information between the school nurse and my child's physician named above as it relates to this medical condition. I further authorize the school nurse to distribute copies of this document in accordance with the distribution list below to ensure the safe and proper care of my child while being transported to and from school as well as during school hours. I understand that professional staff will use the medical information given or received and that this information will not be released to any other party not designated herein.

\_\_\_\_\_  
Parent/Guardian Signature Date