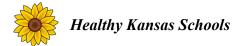


NOTE: Parents are to provide the physician's medical management plan to the school *annually*. The medical orders, along with the health intake below, assist the school nurse in developing an Individual Healthcare Plan for the student.

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	\Box 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 sch	nool activities? 🗆 Yes 🗆 No			
Student's age of onset of asthma symptoms? _	Age at diagnos	sis of asthma?		
What symptoms does student display during a	an asthma episode? (Please c	heck all that apply):		
□ Wheezing □ Coughing	\Box 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?				
\Box 2 nights a month or less	\Box 2 nights a month or less \Box More than 2 nights a month			
□ More than 2 nights a week	□ 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	\Box Often \Box All of the time		
How many times has student been to the emergency room or hospitalized for asthma in the past year?				
$\Box 0 \text{ times}$ $\Box 1 \text{ time}$ $\Box 2 \text{ time}$	mes \Box 3 times	\Box 4 times \Box 5 or more times		
How many days did student miss school last year for asthma symptoms (wheezing, coughing, shortness of breath?)				
\Box 0 days \Box 1-2 days \Box 3-5 da	ays □ 6-9 days □	10-14 days \Box 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)				
\Box Animals/Pets \Box Changes in weather/cold or heat \Box Dust/dust mites \Box 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? \Box Yes \Box No

Does anybody in the household smoke? \Box Yes \Box 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? \Box Yes \Box 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?

 \Box Yes \Box 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: _____