ASTHMA INTAKE FORM

DOES YOUR CHILD HAVE ASTHMA?

☐ **No** – STOP HERE

☐ **Yes** – Please complete this form

If you have any questions, please contact your child's school nurse.

Date form completed:_____ Student ID_____

Student Name: _____Birth date:_____

Parent/Guardian Name & Phone #:_____

Name of person completing form and relationship (i.e. mom, dad, grandma):_____

Health Care Provider for asthma (name & phone #):_____

1. In the past 12 months, how many times has your child visited the ER/urgent care or had an urgent doctor's office visit for asthma?
   ☐ 0 times ☐ 1 times ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

2. In the past 12 months, how many times has your child been hospitalized overnight for asthma?
   ☐ 0 times ☐ 1 times ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

3. In the past 12 months, how many times has your child used oral steroids (prednisone, Orapred) to treat an asthma attack?
   ☐ 0 times ☐ 1 times ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

4. How many days of school did your child miss this past school year because of asthma?
   ☐ 0 days ☐ 1-2 days ☐ 3-5 days ☐ 6-10 days ☐ 11-15 days ☐ 16 or more days

5. In the past 4 weeks, how often has your child used a rescue or reliever medicine (a syrup, inhaler, or breathing machine) to relieve coughing, trouble breathing, or wheezing?
   ☐ Never ☐ 1-2 days/week ☐ 3 or more days/week but not every day ☐ Every day

6. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day?
   ☐ Never ☐ 1-2 days/week ☐ 3 or more days/week but not every day ☐ Every day

7. In the past 4 weeks, how often has your child awakened at night because of coughing, trouble breathing, or wheezing?
   ☐ Never ☐ 1-2 times/month ☐ 3 or more times/month ☐ 2 or more times/week ☐ Every night

8. In the past 4 weeks, how often has your child's asthma bothered or interrupted him/her during normal activities (playing, running around, and sports)?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ All of the time

9. What triggers your child's asthma? (Check all that apply)
   ☐ Illness (colds) ☐ Smoke Allergies: ☐ Cat ☐ Dog ☐ Dust ☐ Mold ☐ Pollen
   ☐ Emotions (crying, laughing, stress) ☐ Exercise/physical activity ☐ Food: _____
   ☐ Weather changes ☐ Strong odors/smells Other:_____

10. Please write the names or colors of medicines (inhalers/puffers, pills, liquids, nebulizers) your child takes for asthma and allergies (the ones every day and as needed) and give the nurse a copy of your written asthma treatment plan.

List Names or Colors of Medicines Used for Asthma	

11. How well does your child take asthma medicines? (Only one answer)
   ☐ Takes medicine by self ☐ Needs help taking medicine ☐ Not using medicine now

Parent Signature_____Date_____School Nurse Reviewed_____Date_____

¿SU HIJO PADECE DE ASMA?

☐ **No** – **NO DEBE LLENAR ESTE FORMULARIO**

☐ **Sí** – Debe llenar este formulario

Si tiene alguna pregunta, póngase en contacto con la enfermera de la escuela de su hijo.

Fecha en que llena el formulario:_____ N.º de ID del estudiante:_____

Nombre del estudiante: _____ Fecha de nacimiento:_____

Nombre del padre o tutor legal y n.º de teléfono:_____

Nombre de la persona que llena el formulario y parentesco (p.ej. mamá, papá, abuela):_____

Médico tratante del asma (nombre y n.º de teléfono):_____

1. ¿Cuantas veces en los últimos 12 meses ha ido su hijo a una sala de emergencia /de cuidados urgentes o al médico debido al asma?
   ☐ 0 veces ☐ 1 vez ☐ 2 veces ☐ 3 veces ☐ 4 veces ☐ 5 veces o más

2. ¿Cuántas veces en los últimos 12 meses ha sido hospitalizado su hijo por causa del asma?
   ☐ 0 veces ☐ 1 vez ☐ 2 veces ☐ 3 veces ☐ 4 veces ☐ 5 veces o más

3. ¿Cuántas veces en los últimos 12 meses ha usado su hijo corticoesteroides orales (prednisona, Orapred) para tratar una crisis asmática?
   ☐ 0 veces ☐ 1 vez ☐ 2 veces ☐ 3 veces ☐ 4 veces ☐ 5 veces o más

4. ¿Cuántos días faltó a clases su hijo en los últimos 12 meses debido al asma?
   ☐ 0 días ☐ 1-2 días ☐ 3-5 días ☐ 6-10 días ☐ 11-15 días ☐ 16 o más días

5. ¿Con qué frecuencia ha usado su hijo una medicina de rescate o de alivio (un jarabe, inhalador o máquina para respirar) en las últimas 4 semanas para aliviar la tos, problemas respiratorios o sibilancias?
   ☐ Nunca ☐ 1-2 días a la semana ☐ 3 o más días a la semana pero no todos los días ☐ Todos los días

6. ¿En las últimas 4 semanas, con cuánta frecuencia ha tenido su hijo tos, problemas respiratorios o sibilancias en la mañana o durante el día?
   ☐ Nunca ☐ 1-2 días a la semana ☐ 3 o más días a la semana pero no todos los días ☐ Todos los días

7. ¿En las últimas 4 semanas, con cuánta frecuencia su hijo se ha despertado en la noche por causa de la tos, problemas respiratorios o sibilancias?
   ☐ Nunca ☐ 1-2 veces al mes ☐ 3 o más veces al mes ☐ 2 o más veces a la semana ☐ Todas las noches

8. ¿Con qué frecuencia el asma de su hijo ha sido una molestia o ha interrumpido sus actividades normales (jugar, correr y deportes) en las últimas 4 semanas?
   ☐ Nunca ☐ Rara vez ☐ Algunas veces ☐ Con frecuencia ☐ Todo el tiempo

9. ¿Qué provoca el asma de su hijo? (Marque todas las que correspondan)
   ☐ Enfermedad (resfriados) ☐ Humo Alergias: ☐ Gato ☐ Perro ☐ Polvo ☐ Moho ☐ Polen
   ☐ Emociones (llorar, reír, estrés) ☐ Ejercicio/actividad física ☐ Alimentos: _____
   ☐ Cambios de tiempo ☐ Olores fuertes Otro:_____

10. Escriba los nombres o colores de las medicinas (inhaladores, pastillas, líquidos, nebulizadores) que su hijo toma para el asma y las alergias (las que usa a diario y según sea necesario) y entregue a la enfermera una copia de su plan escrito para el tratamiento del asma.

Liste los nombres o colores de las medicinas usadas para el asma	

11. ¿Cómo toma su hijo las medicinas para el asma? (Solo una respuesta)
   ☐ Toma la medicina solo ☐ Necesita ayuda para tomar la medicina ☐ En este momento, no toma medicinas

Firma del padre _____Fecha_____Revisado por la enfermera escolar_____Fecha _____

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS

PARENT/GUARDIAN COMPLETE AND SIGN:

School/grade: _____

Child Name: _____ Birthdate: _____

Parent/Guardian Name: _____ Phone: _____

Healthcare Provider Name: _____ Phone: _____

Triggers: ☐Weather (cold air, wind) ☐Illness ☐Exercise ☐Smoke ☐Dust ☐Pollen ☐Other: _____

☐Life threatening allergy, specify: _____

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our healthcare provider. I assume full responsibility for providing the school/program prescribed medication and supplies, and to comply with board policies, if applicable. I am aware 911 may be called if a quick relief inhaler is not at school and my child/youth is experiencing symptoms. I approve this care plan for my child/youth.

PARENT SIGNATURE	DATE	NURSE/CCHC SIGNATURE	DATE
_____	_____	_____	_____

HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF (RESCUE) MEDICATION: ☐ Albuterol ☐ Other: _____

Common side effects: ↑ heart rate, tremor ☐ Have child use spacer with inhaler.

Controller medication used at home: _____

	IF YOU SEE THIS:	DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Doing usual activities	Pretreat strenuous activity: ☐Not required ☐Routine ☐Student/Parent request Give QUICK RELIEF MED 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs ☐ Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Complains of tight chest • Not able to do activities, but talking in complete sentences • Peak flow: _____& _____	1. Stop physical activity. 2. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs 3. Stay with child/youth and maintain sitting position. 4. **REPEAT** QUICK RELIEF MED, if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs 5. Child/youth may go back to normal activities, once symptoms are relieved. 6. Notify parents/guardians and school nurse. ***If symptoms do not improve or worsen, follow RED ZONE.***
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray or blue • ↓ Level of consciousness • Peak flow < _____	1. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs ▪ Refer to anaphylaxis plan, if child/youth has life-threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians and school nurse. 5. If symptoms do not improve, **REPEAT** QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs every 5 minutes until EMS arrives. *School personnel should not drive student to hospital.*

PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

☐ Student understands proper use of asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse and completion of contract.

☐ Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

HEALTH CARE PROVIDER SIGNATURE	PRINT PROVIDER NAME	DATE	FAX	PHONE
_____	_____	_____	_____	_____

Copies of plan provided to: ☐Teacher(s) ☐PhysEd/Coach ☐Principal ☐Main Office ☐Bus Driver Other_____

Asthma Self Carry Contract **The Vanguard School 2021-2022 Grade: _____**

STUDENT :_____ DOB:_____

- ☐ I plan to keep my rescue inhaler with me at school rather than in the school health office.
- ☐ I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.
- ☐ I will notify the school health office if I am having more difficulty than usual with my asthma.
- ☐ I will not allow any other person to use my inhaler.

Student's Signature _____Date _____

PARENT/GUARDIAN:_____

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

- ☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.
- ☐ It has been recommended to me that a back-up rescue inhaler be provided to the Health Office for emergencies.
- ☐ I will review the status of the student's asthma with the student on a regular basis as agreed in the health care plan.
- ☐ I will provide the school a Health Care Provider signed medication authorization for this medication.

Parent's Signature _____Date _____

School Nurse: Robin Smith, RN BSN The Vanguard School

- ☐ The above student has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pretreatment with an inhaler prior to exercise.
- ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.
- ☐ I will review the medication authorization provided by the parent and signed by the health care provider.

RN/Nurse's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Health Assistant Signature: _____ Date: _____
School Administrator's Signature: _____ Date: _____