Health and Wellness Services

1200 South Barr Street • Fort Wayne, IN 46802 • Phone: 260.467.1080 • Fax: 260.467.2862

ASTHMA Parent-Physician Information 2019-20

PARENT INFORMATION

Student Name: ______________________________ Grade ____________ D.O.B. ________________ School _____________ Rm # ____________

Parent/Legal Guardian Name: ____ Daytime Phone: ___________ Cell: _______

Emergency Phone Contact #1: ____ Relationship: ___________ Daytime Phone: __________ Cell: _________

Emergency Phone Contact #2: ____ Relationship: ___________ Daytime Phone: __________ Cell: _________

Family Doctor: ________________________ Telephone: _______________ Asthma Doctor: ___________________________ Telephone: ____________

Hospital Preference ❒ Lutheran (W. Jefferson) ❒ Lutheran (Dupont) ❒ Parkview (North) ❒ Parkview (Randallia) ❒ Saint Joseph

Identify the things that may trigger asthma symptoms in your child -Check all that apply

☐Animals ☐Exercise ☐ Extreme heat or cold ☐ Colds/flu ☐ Pollens ☐Smoke ☐Allergy to ____________
☐Other ______________________________

Asthma History

Age when asthma began __________ Date of last doctor's appointment for asthma ____________ Days missed last year with asthma ________
In the last year, how many overnight hospitalizations did your child have due to asthma? ______ How many ER visits? ______

Rate your child's asthma (Circle one) (not severe) 1 2 3 4 5 6 7 8 9 10 (most severe)

My child knows how to properly use an inhaler ❒ YES ❒ NO My child uses a spacer with the inhaler ❒ YES ❒ NO Number of times per week uses a rescue inhaler ______

Daily (Controller) Medication Plan for Asthma/Allergy- ***What medication/s does your child take daily to prevent/control asthma?***

Medication Name	Amount	When Used (Time)
1.		
2.		

Emergency Medications – ***What medication/s does your child take for an emergency asthma or allergy attack?***

Medication Name	Amount	When Used (Time)
1.		
2.		
3.		

Outside Activity and Field Trips. ***The following medications should accompany my child when participating in outside activity and field trips*****. Include DIRECTIONS**

1.	2.

I agree that this information (plan) may be shared with the appropriate staff, who works with the student, on a need to know basis. I hereby release Fort Wayne Community School District and any of its agents, employees, administrators, from any liability for any injury or harm which is suffered by my child as a result of our District's agreement to honor the above request. I agree to allow the school nurse to contact my physician about my child's asthma treatment plan for school. I agree to keep the school nurse updated in writing about my child's health, and contact the school nurse in writing if any changes are made in the plan.

Parent Signature ___________________________________ **Date**________________

PHYSICIAN INFORMATION *This section is only to be filled out by the health care provider and is only necessary for the special circumstances listed below.*

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Student Name____ D.O.B. ___________

This student has a diagnosis of asthma and will require the following modifications to the school day to ensure his/her safety and wellbeing.

Student will need emergency asthma medications for the following symptoms

☐ on demand ☐before activity ☐coughing ☐difficulty breathing ☐chest tightness ☐wheezing ☐has a peak flow reading at or below___________
☐ may repeat medication dose x1 if no improvement ☐Other _______________________

EMERGENCY ASTHMA MEDICATIONS TO BE USED AT SCHOOL

MEDICATION	AMOUNT	FREQUENCY	MAY REPEAT DOSE	SPECIAL DIRECTIONS
1.				
2.				

☐ Student uses a peak flow meter.

Students tests peak follow ☐ daily at school ☐ only when symptomatic special directions for interventions ________________________________

☐ Student requires modifications for gym class

☐ use inhaler before activity ☐ no gym class under the following circumstances ____

☐ Student requires modifications for outdoor recess ____

☐ use inhaler before activity ☐ no outdoor recess under the following circumstances

☐ Student may carry own inhaler and administer without supervision while at school

☐ Other modifications____

Physician Signature____ Date________________________