



Health and Wellness Services

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

ASTHMA Parent-Physician Information 2018-19

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.
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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 _____



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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.*

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 _____