



# Health and Wellness Services

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

## ASTHMA Parent-Physician Information 2022-23

### 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 \_\_\_\_\_