Questionnaire for Parents of Students with Asthma

Student's Name: _____ School Year _____
School _____Grade_____ Teacher_____
Parent's Name(s) _____ Home Phone_____ Work _____
Name of Primary Care Provider_____ Phone_____
Name of Asthma Specialist _____ Phone _____
The following information is helpful to your child's school nurse and school staff in determining any special needs for your child. Please answer the questions to the best of your ability. If you would like a conference with the school nurse, please call.
Nurse's Name _____ Phone_____

1. How long has your child had asthma?

2. Please rate the severity of his/her asthma
   (Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. About how many days did your student miss last year due to asthma?

4. What triggers your child's asthma attacks? Check any that may apply.
   ___Illness ___Emotions ___ Medications ___ Foods
   ___Weather ___ Cigarette or other smoke ___Chemical odors
   ___Fatigue
   Other (please list) _____
   Allergies (please list) _____

5. What does your child do at home to relieve wheezing during an asthma attack?
   ___ Breathing exercise Takes medication: ___ Inhaler
   ___Rest/Relaxation ___Nebulizer
   ___Drinks liquids ___ Oral Meds

6. Please list the medications your child takes for asthma(every day and as needed)
   Name of Medication Dose Frequency

   At School_____
   _____

   At Home_____
   _____

For medications to be given at school there are special procedures to follow which the school nurse will discuss with you.

7. If your child does not respond to medication, what action do you advise school personnel to take?

_____
_____

8. What, if any, side effects does your child have from the medications?

_____

9. Has your child been taught how to use an extension tube, pulmonary aid, aero chamber, inspirease kit or other device with his/her inhaler?

_____

10. How many times has your child been treated in the emergency room for asthma in the past two years? _____ How many times has your child been hospitalized overnight or longer for asthma in the past two years? _____ How often does your child see his/her doctor for routine asthma evaluations? _____

11. Does your child need any special considerations related to his her asthma while at school? Check any that apply and describe briefly:

___Modified gym class _____
___Modified recess outside _____
___No animal pets in the classroom _____
___ Avoiding certain foods_____
___Emotional or behavior concerns _____
___Special consideration while on field trips_____
___Special transportation to and from school _____
___Other _____

12. Do you know your child's baseline peak flow rate? ___No ___Yes _____Rate

13. Do you authorize the school health personnel to assess your student's peak flow rate at school? ___Yes ___ No

14. Do you have any other concerns regarding your child's asthma and his/her school attendance? (if yes, please describe) _____

_____

Signature _____ Date: _____

Thank you for your time and assistance in assessing your child's special needs in school. This information may be shared only on a confidential and need to know basis.

NEW MEXICO ASTHMA ACTION PLAN FOR SCHOOLS

Date_____

School District _____ **School Name** _____

School Nurse / Health Asst. _____ **School Phone # / FAX #** _____ /_____

PARENT/GUARDIAN: Please complete the information in the top sections and sign consent at bottom of the page.

Student Name	**Date of Birth**	**Student #**
***Health Care Provider Name/Title**	**Provider's Office Phone / FAX #**	
Parent/Guardian	**Parent's Phone #s**	
Emergency Contact	**Contact Phone #s**	
Allergies to Medications:		

Date of last medical exam: ___/___/_____	**Inhaler is kept:** ☐ with student ☐ Health Office ☐ Classroom ☐ Other: _____
Date of last Flu Shot: ___/___/_____	**Inhaler expires on:** ___/___/_____

Asthma Triggers Identified (Things that make your asthma worse):
☐ Exercise ☐ Colds ☐ Smoke (tobacco, fires, incense) ☐ Pollen ☐ Dust ☐ Strong Odors ☐ Mold/moisture ☐ Stress ☐ Pests (rodents, cockroaches)
☐ Gastroesophogeal reflux ☐ Season: Fall, Winter, Spring, Summer ☐ Animals ☐ Other (food allergies):_____

HEALTH CARE PROVIDER: Please complete Severity Level, Zone Information and Medical Order Below

Asthma Severity: ☐ Intermittent *or* Persistent: ☐ Mild ☐ Moderate ☐ Severe

Green Zone: Go - You're Doing Well! Take Control Medications EVERYDAY to Prevent Symptoms

You have **ALL** of these:
- Breathing is easy
- No cough or wheeze
- Can work and play
- Sleep through the night

Peak Flow may be useful for some students.

☐ ***No** controller medication is prescribed.*

☐ _____, _____ puff(s) MDI **with spacer** _____ times a day
Inhaled corticosteroid or inhaled corticosteroid/long-acting β-agonist

☐ _____, _____nebulizer treatment(s) _____ times a day
Inhaled corticosteroid

☐ _____, take _____ by mouth once daily at bedtime
Leukotriene antagonist — Always rinse mouth after using your daily inhaled medication.

For asthma with exercise, ADD:

☐ _____, _____ puff(s) MDI with spacer 5 to 15 minutes before exercise

Inhalers work better with spacers. Always use a mask when prescribed.

Yellow Zone: Slow Down! Continue Green Zone Medicine & ADD RESCUE Medicines-

You have ***ANY*** of these:
- **First signs of a cold**
- Cough or mild wheeze
- Exposure to known trigger
- Problems sleeping, playing, or working
- Cough at night

DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given.

☐ _____, _____ puff(s) MDI **with spacer** & every_____ hours as needed
Fast-acting inhaled β-agonist

OR

☐ _____, _____ **nebulizer** treatment(s) & every_____ hours as needed
Fast-acting inhaled β-agonist

Red Zone: DANGER – Get Help! TAKE THESE MEDICINES NOW AND GET MEDICAL HELP NOW!

Your asthma is getting worse fast:
- Cannot talk, eat, or walk well
- Medicine is not helping or
- Getting worse, not better
- Breathing hard & fast
- Blue lips & fingernails

DO NOT LEAVE STUDENT ALONE! Call 911 and start treatment then call Parent/Guardian.

☐ _____, _____ puff(s) MDI **with spacer every_____ minutes** until EMS arrives
Fast-acting inhaled β-agonist

☐ **For schools with 02:** (Only use Oxygen if Pulse Oximeter available)
Give 02 to keep sat. above 92% unless otherwise contraindicated. Check sat. continually until EMS arrives.

√ *Make an appointment with your doctor within **two days** of an **emergency visit, hospitalization**, or anytime for **ANY** problem or question about asthma*
School Nurse: Call provider for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms
Parents: Call your child's doctor for control concerns or if rescue medication is used more than 2 times per week for asthma symptoms

HEALTH CARE PROVIDER ORDER AND SCHOOL MEDICATION CONSENT

Check all that apply:

____ Student has been instructed in the proper use of his/her asthma medications and IS ABLE TO CARRY AND SELF-ADMINISTER his/her INHALER AT SCHOOL.

____ Student is to notify designated school health personnel after using inhaler at school.

____ Student needs supervision or assistance when using inhaler.

____ Student is unable to carry his/her inhaler while at school.

***SIGNATURE/TITLE**: _____ **DATE**: _____

Parent/Guardian:

I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider, if necessary, and share this plan with the SBHC, if applicable. I assume full responsibility for providing the school with the prescribed medications and delivery of monitoring devices. I give my permission for the school to share the above information with school staff that need to know and permission for my child to participate in any asthma educational learning opportunities at school.

SIGNATURE: _____ **DATE:**_____

SCHOOL NURSE: _____ **DATE:** _____

PLAN DE ACCIÓN EN CASO DE ASMA PARA LAS ESCUELAS EN NUEVO MÉXICO

Fecha_____

Distrito escolar _____ **Nombre de la escuela**_____

Enfermera/Ayudante de salud _____ **# de teléfono/FAX de la escuela**_____

PADRE DE FAMILIA/GUARDIAN: ***por favor complete la información y firme siguientes formas abajo:***

Nombre del estudiante	**Fecha de nacimiento**	**# del estudiante**
***Nombre/Título de la persona que da ayuda médica**	***# de teléfono / FAX de esta persona**	
Padre de familia/Guardián	**#s de teléfono de esta persona**	
Contacto de emergencia	**#s de teléfono de esta persona**	

La fecha de la última visita de estudiante al médico: ___/___/___

VERDE: ¡ADELANTE!
Use la medicina de CONTROL diariamente

AMARILLO: ¡CAUTELA!
Añada la medicina de rescate

ROJO: ¡EMERGENCIA!
¡Consiga ayuda médica YA!

Substancias que causan el asma: (Que la empeoran) ☐ Ejercicio ☐Resfriados ☐Humo (de tabaco, de incendios, de incienso) ☐Polvo ☐ Olores fuertes ☐ Moho/humedad ☐ Estrés/emocione ☐ Insectos (ratones, cucaracha ☐ Reflujo gastroesofágico ☐ Estación: otoño, invierno, primavera, verano ☐ Polen ☐ Animales _____ **Otros** (alergias del alimento) _____

Lugar donde se guarda el inhalador
☐ con el estudiante
☐ En el salón
☐ En la oficina de salud
☐ En otro lugar _____

Fecha de la última vacuna de la gripe ___/___/___

Alergias a medicinas:

Proveedor de asistencia médica: Por favor complete el Nivel de Severidad, Información de Zona y Orden Médica abajo

Severidad del Asma: ☐ Intermitente *o* Persistente: ☐ Leve ☐ Moderada ☐ Severa

Zona verde: ¡Adelante! Tome la medicina de control TODOS LOS DÍAS

Usted tiene TODOS estos síntomas:
- Respira fácilmente
- No está tosiendo ni tiene sibilancia en el pecho
- Puede trabajar y jugar
- No tiene síntomas en la noche

Flujo del aire óptimo (opcional):
Mayor de≥ _____
(Más del 80% del flujo del aire personal)

Flujo del aire personal: _____

☐ No necesita medicina de control recetada.

☐ _____, ____ (aspiraciones) **con cámara de inhalación** _____ veces al día
Corticoesteroide inhalado o con medicinas agonistas β a largo plazo

☐ _____, _____ tratamientos con nebulizador ____ veces al día
Corticoesteroide inhalado

☐ _____, tomado _____ oralmente una vez al día al acostarse
Antagonista de leucotrienos

Para hacer ejercicio cuando se tiene asma, AÑADA:

☐ _____, ____ aspiraciones con una cámara de inhalación 5 - 15 minutos antes del ejercicio

Para alergias nasales/ambientales, AÑADA:

☐ _____

Zona amarilla: ¡Precaución! Continúe la medicina de CONTROL y AÑADA las medicinas de RESCATE-

Usted tiene CUALQUIERA de estos síntomas:
- Tos o un leve silbido
- El pecho se siente oprimido
- Siente los primeros síntomas de un resfriado
- Tiene problemas para dormir, jugar o trabajar

Flujo del aire óptimo (opcional):
_____ a _____
(50% - 80% del flujo del aire personal)

¡NO DEJE SOLO AL ESTUDIANTE! Llame al padre/guardián cuando le dé la medicina de rescate.

☐ _____, _____ (aspiraciones) MDI **con cámara de inhalación**_____ **veces al día**
Agonistas inhalados β de acción rápida

☐ _____, _____ **tratamientos** con nebulizador ____ veces al día tal como sea necesario
Agonistas inhalados β de acción rápida

☐ Otros _____

¡Llame al MÉDICO si usted tiene estos síntomas más de dos veces a la semana, o si su medicina de rescate no trabaja! Si los síntomas NO se mejoran O el flujo del aire personal NO se mejora, vaya a la ZONA ROJA.

Zona roja: ¡EMERGENCIA! Continúe las medicinas de CONTROL, AÑADA las medicinas de RESCATE y CONSIGA AYUDA!

Usted tiene CUALQUIERA de estos síntomas:
- No puede hablar, comer o caminar bien
- La medicina no le está ayudando o
- Se siente peor, no major
- Está respirando duro y rápido
- Tiene los labios y las uñas azules

Flujo del aire óptimo (opcional):
Menos del ≤ _____
(Menos del 50% del flujo del aire personal)

¡NO DEJE SOLO AL ESTUDIANTE!→ Llame a Emergencias 911 y empiece el tratamiento

☐ _____ , ____ (aspiraciones) (MDI con cámara de inhalación y cada 20 minutos hasta que lleguen los paramédicos, O

☐ _____, _____ tratamientos con nebulizador cada 20 minutos hasta que los paramédicos lleguen

Llame al 911 inmediatamente* y empiece el tratamiento *y llame al padre o guardián

Si están disponibles oxígeno y oxímetro de pulso:

☐ Si la saturación de O2 es ≤ _____ administre oxígeno a _____ litro/min. cada ____ minutos

ORDENES MÉDICAS Y CONSENTIMIENTO PARA DAR LAS MEDICINAS EN LA ESCUELA *(Marque todo lo que aplique)*

___ El estudiante ha recibido instrucciones en el uso apropiado de sus medicinas para el asma y puede administrarse solo SU INHALADOR EN LA ESCUELA

___ El estudiante debe de avisar al personal de salud designado después de usar su inhalador en la escuela

___ El estudiante necesita supervisión o ayuda cuando usa el inhalador

___ El estudiante no puede llevar su inhalador mientras está en la escuela

***FIRMA/ TÍTULO** _____ Fecha _____

Padre/Guardián:
Yo apruebo este plan de acción para el asma, y doy mi consentimiento para que la enfermera escolar o el personal escolar entrenado para ello sigan este plan, le den las medicinas a mi niño y se pongan en contacto con mi doctor, si es necesario. Yo asumo la responsabilidad plena de dar a la escuela las medicinas recetadas y los aparatos pertinentes para dar el tratamiento y la vigilancia del asma. Yo autorizo a la escuela para que compartan esta información con el personal de la escuela que necesite saberla, y le doy permiso a mi niño para que participe en cualquier oportunidad educativa para aprender sobre el asma en la escuela.

FIRMA: _____ FECHA _____

ENFERMERA ESCOLAR: _____ FECHA _____

Alamogordo Public Schools
Health Services

TO DETERMINE IF A CHILD SHOULD CARRY THEIR OWN INHALERS THEY SHOULD BE ABLE TO ANSWER THE FOLLOWING:

1. What is the name of your inhaler?
2. If you inhaler is not helping you breath better, what would you do?
3. What time does the clock say? What is 4 hours from that time?
4. Show me how to use your inhaler.
5. How do you know that you need to use your inhaler?
6. When your breathing feels bad, what do you do for it?
7. How is your breathing on a bad breathing day?
8. What is asthma?

In the event the child is unable to answer above questions, the parent and prescribing physician should be notified and encouraged to maintain the inhaler in the health office.