HS0021
Rev. 5/03

STUDENT ASTHMA INFORMATION ACTION CARD

(Reactive Airway Disease)
Health Services
Lincoln Public Schools

Name ______________________ **Grade** __________

Dear Parent/Guardian,

Your child's health record shows asthma or use of asthma medications.

Check here if:

- ❑ Your child has had an asthma-type episode in the last three years.
- ❑ Your child currently uses medications to improve breathing.
- ❑ Your child has been in the hospital or the emergency room for breathing problems in the last year.

If you checked any of the above, please complete this form (both sides) so we can care for your child correctly at school. It is very important that we have emergency contact information for you in case your child needs you.

If you have any questions about asthma at school, please contact the school nurse. The nurse's name and phone number are shown here:

School Nurse ______________ Phone Number __________

Parent/Guardian #1 Name ______________________

Address ______________________

Ph. (H) __________ Ph. (W) __________

Parent/Guardian #2 Name ______________________

Address ______________________

Ph. (H) __________ Ph. (W) __________

Emergency phone #1 Name ______________________

Ph. (H) ______________________

Emergency phone #2 Name ______________________

Ph. (H) ______________________

Your child's asthma doctor: Name ______________________

Ph. ______________________

Other doctors (or clinics) who know your child ______________________

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Hospital Preference ______________________

Please mark a box that would best describe your child's asthma before taking treatment:

❑ **MILD INTERMITTENT**
- a) Daytime symptoms: 2 or less times per week
- b) Nighttime symptoms: 2 or less times per month

❑ **MILD PERSISTENT**
- a) Daytime symptoms: more than 2 times per week but less than daily
- b) Nighttime symptoms: more than 2 times per month

❑ **MODERATE PERSISTENT**
- a) Daytime symptoms: occur daily
- b) Nighttime symptoms: more than 1 time per week

❑ **SEVERE PERSISTENT**
- a) Daytime symptoms: continual
- b) Nighttime symptoms: frequently awakens at night with symptoms
- c) Physical activity is limited

Check the triggers that cause your child to have breathing problems:

- ❑ Exercise
- ❑ Respiratory Infections
- ❑ Change in Temperature
- ❑ Animals
- ❑ Food __________
- ❑ Other __________
- ❑ Comments ______________________
- ❑ Strong odors or fumes
- ❑ Chalk dust
- ❑ Carpets in the room
- ❑ Pollens
- ❑ Molds

Check the signs your child shows when he/she is about to have breathing problems:

- ❑ cough
- ❑ wheeze
- ❑ other ______________________
- ❑ shortness of breath
- ❑ anxiety
- ❑ restlessness
- ❑ complaints of chest tightness

EXERCISE/PE PLAN (Check one):

- ❑ Use inhaler before aerobic workout, then participate normally.
- ❑ Use inhaler before aerobic workout, attempt moderate participate with frequent walking.
- ❑ Not to participate in extensive running (mile run, pacer fitness run, 12-minute timed run), but will walk instead.
- ❑ Other

Students with asthma are encouraged to participate fully in physical activity with rest as needed!

The other side of this form describes the ways your child's breathing problems are managed. Date __________

Student Name ______________________________ Grade ________

Personal Best Peak Flow Reading:__________ L/Min.

GREEN ZONE medication plan: My child takes the following medications *daily.* (Please list ***name, dose*** and ***frequency*** of each.)__________ __________ __________ __________ __________ __________ Medication regimen to take before exercise: __________ ❏ Check if student uses an aerochamber or spacer.	**GREEN ZONE** • Doing well • No daytime symptoms • Sleeping without breathing problems • Peak flow 80-100% of personal best	**GREEN ZONE peak flow range:** [ ] to [ ] **This is where the student should be everyday.**
YELLOW ZONE medication plan for mild/moderate symptoms: __________ __________ __________ If no improvement in 15 minutes: __________ __________ If no improvement in 15 minutes: __________ __________	**YELLOW ZONE** • Cough or wheeze may be present • Becomes short of breath with activity • Chest tightness may be present • Peak flow 50-80% of personal best	**YELLOW ZONE peak flow range:** [ ] to [ ] **This is not where the student should be everyday. Take action.**
RED ZONE medications for severe symptoms: First take this medicine: __________ __________ **Get help from a doctor now!** **Dr.** __________ **Medicine** __________ **If no improvement in 15 minutes or if nails or lips are blue and breathing is difficult, call 911 and implement emergency epinephrine protocol** ❏ **Check if student has an epi pen.**	**RED ZONE** • Wheeze, cough, and /or shortness of breath return within four hours of medication • Experiencing retractions • Experiencing chest pain/tightness • Difficulty eating or drinking • Difficulty walking or talking • Peak flow less than 50% of personal best • Worsening symptoms after treatments	**RED ZONE peak flow range:** [ ] to [ ] **Medical Alert. Symptoms are serious and student needs help.**

COMMENTS/SPECIAL INSTRUCTIONS: ______________________________

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The information provided by the parent/guardian here may be shared with other school staff to promote your child’s safety and educational success at school.

PERSON COMPLETING THIS FORM:

Name (Signature) ______________________________ Date ________