**Asthma Medical Request / Referral**

**Date:   
Student: ID#: DOB:   
Parent/Guardian:   
  
Dear Health Care Provider** (name if known), this student was seen in the school health office for problems with his/her asthma. The following is a brief summary of school observations:

| **Subjective/Objective** |
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| **Presenting symptoms:**  Cough Tight Chest Wheeze SOB Respiratory rate Acute respiratory distress  Other |
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| **Precipitating Factors:**  Cold symptoms Exercise Cold air  Reports not taking daily long-term control medicine regularly  Other trigger/irritant/allergen exposure (specify)  Other: |
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| **School absences this academic year #**  **Other data/comments:** |
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| **Medication in the health office:**  Quick-relief medicine  Via MDI with spacer Via nebulizer  Reports not taking daily long-term control medicine regularly Other:  No medicine is in the health office |
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| **Other data/comments:** |
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| **Assessment** |
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| **To support this student’s asthma management at school, please send/order/arrange:**  Medical evaluation of this child  Current Asthma Action Plan signed by the health care provider (may serve as medication consent form)  Medication / spacer / PF meter for school (circle item)  Assess need for / adjustment of controller medication’s for this child  Home care referral (for asthma education, environmental assessment and follow-up in home)  Asthma Case Management (for care coordination, arranging education, transportation, follow-up)  Other:   Please respond:  by (date)  after this child is seen in clinic  **School Nurse:** **Date:**  **Phone/pager#:** |
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| **Plan** |
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| Clinic will contact student / family to schedule an asthma check-up / evaluation  See attached new or revised Asthma Action Plan  Continue with current Asthma Action Plan  Medication / Spacer / PF meter refill called to student’s pharmacy  Medication’s approved for use at school (list)     Refer to PHN / Home Care / Case Management (specify agency or program, if preference):      Above requests by school nurse is/are approved  Other:  **Health Care Provider name/signature:**  **Clinic staff name/signature:**  **Date returned:**  **FAX or SEND to:** FAX#:  Address: |
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