Medical Asthma Evaluation Request

Student ____________________ Student ID # ____________
DOB __________
School _____________________________ Parent/Guardian ______________________________

Dear Health Care Provider

_________________________________, this student was seen in the school health office for problems with his/her asthma. The following is a brief summary of school observations:

Presenting symptoms:
- ❑ Cough ❑ Wheeze
- ❑ Tight chest ❑ SOB
- ❑ Respiratory rate _________
- ❑ Acute respiratory distress
- ❑ Other _________________

School absences
____

Comments:
____
____
____

Precipitating Factors:
- ❑ Cold symptoms ❑ Exercise ❑ Cold Air
- ❑ Other trigger/irritant/allergen exposure (specify) __________________
- ❑ Reports not taking daily long term control medicine regularly
- ❑ Other ____

Medication in the health office:
- ❑ Quick-relief medicine ____
  __ via MDI with spacer __ via nebulizer __ via breath-actuated MDI
- ❑ Long term Control medicine __________________________________
- ❑ Other

Other data/comments:

____

To support this student's asthma management at school, please address:
- ❑ 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)
- ❑ 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

School Nurse: ____ Date Request Sent: _________

Date Copy Sent to Parent: ___________________________________

Adapted from: Minneapolis Healthy Learners Asthma Initiative