**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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