



# ASTHMA CASE MANAGEMENT FORM

Student Name \_\_\_\_\_ School Year \_\_\_\_\_ Grade \_\_\_\_\_

## Annual intensive case management summary for nurse case manager

School year \_\_\_\_\_ School \_\_\_\_\_ School Nurse \_\_\_\_\_

Student Name \_\_\_\_\_ ID # \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Health Care Provider \_\_\_\_\_

Allergist/Pulmonologist \_\_\_\_\_ Date of Asthma Action Plan \_\_\_\_\_

### Severity

#### Severity established by:

Doctor  School Nurse  Not Established

#### Asthma Severity:

Intermittent  Mild Persistent  
 Moderate Persistent  Severe Persistent  
 Exercise Induced

#### Known Allergies:

**Known Triggers (circle):** Dust mites, molds, pollens, hair, animal dander, cockroaches, cold, exercise, colds, chemicals, sinus infections, cigarette smoke, exhaust, foods, yelling, crying, laughing, other \_\_\_\_\_

#### Current Treatments:

**Takes control medication at home or school:**  Yes  No

#### Quick relief medication (e.g. Albuterol):

At home  At school  None

**Self-carry:**  At home  At school  None

**Peak flow:**  At home  At school  None

**Spacer:**  At home  At school  None

**Nebulizer:**  At home  At school  None

**Flu/Pneumonia Vaccine:**  Yes  No  Don't know

**Receiving Allergy Shots:**  Yes  No  Don't know

### School Related Asthma Events

*(see worksheet, next page)*

Date form completed \_\_\_\_\_

Visits to school health office for preventative care \_\_\_\_\_

ED visits for asthma (if known) \_\_\_\_\_

Visits to health office for asthma symptoms \_\_\_\_\_

911 calls for asthma \_\_\_\_\_

Days sent home due to asthma \_\_\_\_\_

Hospitalizations for asthma (if known) \_\_\_\_\_

Total days absent \_\_\_\_\_

Days absent known to be due to asthma \_\_\_\_\_

School Nurse \_\_\_\_\_

### School Based Interventions

Permission to interact with doctor:  Yes  No

Sent letter to doctor:  Yes  No

Date \_\_\_\_\_

Teach inhaler/spacer technique:  Yes  No

Teach Peak Flow Technique:  Yes  No

Parent Counseling:  Yes  No

Date \_\_\_\_\_

Student Health Counseling:  Yes  No

Peak flow Log:  Yes  No

Asthma Education for Classmates:  Yes  No

Open Airways for Schools:  Yes  No

Teaming Up for Asthma Control:  Yes  No

Other formal asthma education program:  Yes  No

Parent or student support group participation:  Yes  No

Emergency Protocol on file:  Yes  No

Emergency Protocol shared with staff:  Yes  No

P.E. Teacher Education:  Yes  No

Staff Education/Counseling:  Yes  No

If yes, number of staff \_\_\_\_\_

Trigger identification at school:  Yes  No

Trigger modification at school:  Yes  No

Trigger identification at home:  Yes  No

Trigger modification at home:  Yes  No  Don't know

Home visit related to asthma:  Yes  No

Date \_\_\_\_\_

Enrolled in extracurricular asthma program:

Yes  No  Don't know

## ASTHMA CASE MANAGEMENT WORKSHEET

Student \_\_\_\_\_

School year \_\_\_\_\_

<b>Health Appraisal</b>	Date	July/ Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
Communication with Health Care Provider												
Open airways for schools received												
Other classroom asthma programs												
Home visits by school for asthma												
Total days absent												
Days absent due to asthma												
911 calls for asthma												
ED visits for asthma												
Hospitalizations for asthma												

<b>Individual Education</b>	<b>Date</b>	<b>Return Demo by Student</b>	<b>Personal Best Peak Flow</b>
Peak flow instruction/review			
Inhaler instruction/review			
Spacer instruction review			

<b>Individual Education</b>	<b>Date</b>	<b>Comments/Additional Information</b>
Trigger Identification		
Personal trigger modifications		
Preferred for Influenza/ Pneumococcal Vaccine		