Respiratory Care Plan

Student Name:_____ **Birth Date**:___/___/___ **M**__ **F**__

School:_____ **Grade**:_____ **Teacher**:_____ **Rides Bus**: **Y** or **N**

Primary Guardian: _____**Phone**: _____
_____**Phone:** _____

SecondaryGuardian: _____ **Phone**: _____
_____ **Phone**: _____

Emergency Contact: _____ **Phone**: _____

Respiratory History to be completed by parent:

1. **What is your child's respiratory diagnosis? Circle one below.**

   Asthma Reactive Airway Disease Allergens Other_____

2. **Please rate the severity of your child's respiratory disease below.**

   1= not severe 10= severe Please circle one: 1 2 3 4 5 6 7 8 9 10

3. **How many times has your child been treated in the ER or hospitalized for respiratory distress in the past year?** _____

4. **In the past month, how often has your child had coughing, wheezing or breathing difficulty?**

   ___daily ___more than 2 times a week ___2 times a week or less

5. **What triggers your child's respiratory symptoms? (check all that apply)**

   ___colds ___air pollution ___smoke ___animals ___exercise ___dust

   ___carpets ___food ___mold ___pollen ___weather Other: _____

OVER →

6. **What do you do at home to relieve respiratory symptoms? (check all that apply)**

   ___rest ___drink liquids ___medication(s) Other: _____

7. **List any medications your child will need at school to treat their respiratory illness:**

Medication	Dose	How Often

8. **Is your child able to administer their respiratory medication? ___Yes** or **___No**

9. **In the past year, how many times has your child's respiratory illness stopped them from participating in sports, recess, gym or other school activities?**

   ___never ___once in a while ___frequently

Please provide a prescription label for your student's inhaler(s).

If your child has been prescribed a spacer for use with the inhaler, please send a spacer for use at school.

**This information will become part of your child's confidential permanent record. If for any reason you do not wish to respond to part(s) of this form, you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions.*

By signing below, I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentiality maintained by all. I also give my permission for the school nurse/aide to contact the Primary Care Physician or Pulmonologist if further information or clarification is needed.

Parent/Guardian Signature: _____

Date: _____