AMERICAN LUNG ASSOCIATION®

Asthma Case Management Form

School District: _____

ANNUAL INTENSIVE CASE MANAGEMENT SUMMARY FOR NURSES/CASE MANAGERS

ID# _____ **School Year:** _____ **School:** _____ **Race (circle): Asian Black Hispanic White Other**

Name: Last_____ First: _____ MI: _____ Grade: _____

Male ❑ **Female** ❑ **Date of Birth** ____/____/____ **Care Provider**_____

Allergist/Pulmonologist: _____ **Date of Asthma Action Plan:** _____ ❑ None

---

___/___/___
Assessment Date

SEVERITY
Severity established by: ❑ Doctor ❑ School Nurse ❑ Not established
Severity is: ❑ Mild Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent
Exercise Induced? ❑ Yes ❑ No Allergy Testing done: ❑ Yes ❑ No
Known Allergies/Sensitivities: _____

CURRENT TREATMENT
Control Med at home or school (e.g., inhaled steroid, leukotriene modifier, cromolyn)
❑ Yes ❑ No
Quick relief Rx (e.g., Albuterol) ❑ At School ❑ At Home ❑ None
Self-carry ❑ At School ❑ At Home ❑ None **Peak Flow** ❑ At School ❑ At Home ❑ None
Spacer ❑ At School ❑ At Home ❑ None **Nebulizer** ❑ At School ❑ At Home ❑ None
Flu/Pneumo Vaccine ❑ At School ❑ At Home ❑ None ❑ Don't know
Receiving Allergy Shots ❑ At School ❑ At Home ❑ Do Not Know
Enrolled in a special asthma program through health insurance?
❑ At School ❑ At Home ❑ Do Not Know

___/___/___
Assessment Date

SEVERITY
Severity established by: ❑ Doctor ❑ School Nurse ❑ Not established
Severity is: ❑ Mild Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent
Exercise Induced? ❑ Yes ❑ No Allergy Testing done: ❑ Yes ❑ No
Known Allergies/Sensitivities: _____

CURRENT TREATMENT
Control Med at home or school (e.g., inhaled steroid, leukotriene modifier, cromolyn)
❑ Yes ❑ No
Quick relief Rx (e.g., Albuterol) ❑ At School ❑ At Home ❑ None
Self-carry ❑ At School ❑ At Home ❑ None **Peak Flow** ❑ At School ❑ At Home ❑ None
Spacer ❑ At School ❑ At Home ❑ None **Nebulizer** ❑ At School ❑ At Home ❑ None
Flu/Pneumo Vaccine ❑ At School ❑ At Home ❑ None ❑ Don't know
Receiving Allergy Shots ❑ At School ❑ At Home ❑ Do Not Know
Enrolled in a special asthma program through health insurance?
❑ At School ❑ At Home ❑ Do Not Know

Asthma Related School Events (summary of all per school year)

- **See worksheet on other side**
- **Date this form completed** _____

Visits to health room for preventive/education: _____
ED visits for asthma (if known): _____
Visits to health room 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: _____

INTERVENTION DONE THROUGH SCHOOL

Permission to interact with Dr.?
❑ No ❑ Yes Date _____

Sent letter/called doctor?
❑ No ❑ Yes Date _____

Teach inhaler/spacer technique?
❑ No ❑ Yes

Teach peak flow technique?
❑ No ❑ Yes

Parent counseling 1:1?
❑ No ❑ Yes

Student health counseling 1:1?
❑ No ❑ Yes

Peak flow logs?
❑ No ❑ Yes

Asthma education for classmates?
❑ No ❑ Yes

Open Airways for Schools received?
❑ No ❑ Yes Date _____

Parent or student support group?
❑ No ❑ Yes

Emergency protocol on file?
❑ No ❑ Yes

Emergency protocol shared with staff?
❑ No ❑ Yes

P.E. teacher education?
❑ No ❑ Yes

Staff education/counseling?
❑ No (# of staff _____) ❑ Yes

Trigger identification at school?
❑ No ❑ Yes

Trigger modification at school?
❑ No ❑ Yes

Trigger identification at home?
❑ No ❑ Yes

Trigger modification at home?
❑ No ❑ Yes

Home visit relating to asthma?
❑ No ❑ Yes Date _____

Referral to asthma camp?
❑ No ❑ Yes

Receiving allergy shots?
❑ No ❑ Yes ❑ Do not know

Enrolled in special asthma program through health insurance?
❑ No ❑ Yes ❑ Do not know

This side is a Worksheet

(for convenience of nurses)

School Year: _____ Student Name: _____

Health Appraisal	Date	July/ Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
Communication with doctor												
Open airways for schools received												
Home visits by school for asthma												
Health room visits for asthma												
Days sent home for asthma												
Total days absent												
Days absent due to asthma												
911 calls for asthma												
ED visits for asthma												
Hospitalization for asthma												

Individual education	Date	Return Demo by Student	Personal Best Peak Flow
Peak flow instruction/review			Date:
Inhaler instruction/review			Date:
Spacer instruction/review			
Trigger identification (e.g., tobacco, pesticides, animals, or birds, dust, cleaning products, solvents, bus/car exhaust, perfumes, molds, cockroach particles, other):		Other Information/Comments	
Personal trigger modifications			
Referred for influenza/pneumococcal/vaccines			
Received influenza/pneumococcal/vaccines			
Support group			

Original form from Anne Arundel County (Maryland) School Health Services; modified by School Health USA of UCSD Community Pediatrics; 2002