INTERNATIONAL SCHOOL OF LATVIA

*** If your child has ASTHMA, please complete this form with the assistance of your child's doctor ***

ASTHMA QUESTIONNAIRE

Child's Name ______________________________ Gender: M / F

1. How long has your child had asthma? *(months, years)* ______________________________

2. How often does your child have asthma attacks? *(daily, weekly, once a month)*______________________________

3. Does your child take medications for asthma?
[ ] daily [ ] only as needed [ ] no medications needed

Please list medications:

Name of Medication	Dosage	Frequency	As needed for	Used at home, school, or both
Ex: Ventolin inhaler	*2 puffs*	*every 6 hours*	*asthma attack*	*At both home & school*

4. Is there a need to keep your child's asthma medication at school? [ ] YES [ ] NO
If YES, please fill out an *Authorization to Administer Medication Form* in the Nurse's Office.
If YES, where would you like your child's medications to be kept?
[ ] in the Nurse's Office [ ] in the classroom [ ] child's backpack

5. Please check off what may start or trigger an asthma attack in your child:

- ☐ Exercise ______________________________
- ☐ Changes in temperature ______________________________
- ☐ Chalk dust ______________________________
- ☐ Animal fur/dander ______________________________
- ☐ Molds ______________________________
- ☐ Insect bites/stings ______________________________
- ☐ Strong odors or fumes ______________________________
- ☐ Respiratory infections ______________________________
- ☐ Carpeting ______________________________
- ☐ Pollens ______________________________
- ☐ Food ______________________________
- ☐ Other ______________________________

6. Besides medications, what other comfort measures help your child during an asthma attack?
____

7. Are there any limitations/restrictions of physical activities at school due to your child's asthma?
If YES, please specify ______________________________

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ASTHMA ACTION PLAN

IF WE SEE THIS…	WE WILL DO THIS….
Complaints of tightness in chest, coughing or wheezing	1. Administer or have student self-administer under observation the following medication(s): Med:_________________________ Dose: _________________ Med: _________________________ Dose: _________________ 2. Observe student closely for any change in condition. 3. Allow student to return to class or normal activity if symptoms are relieved after using medication.
No change in symptoms within _____ minutes of using medication(s).	1. Repeat medication(s) as listed in Step 1 above. 2. Contact parent to inform him/her student has used medication with little or no improvement.
No improvement in symptoms after second dose of meds, and unable to contact parent after second dose administered.	1. Call ambulance. 2. Continue to try and contact parent.
Symptoms worsen!! Student is hunched over, with difficulty breathing, unable to speak, neck and shoulder muscles assisting in breathing effort, lips and/or cuticles blue in color	1. Call ambulance. 2. Call parent. 3. Remain with student until EMS personnel arrive.
Student becomes unconscious	1. Start CPR. 2. Call ambulance. 3. Call parent/guardian.

● I give permission for my child to be transported by ambulance in the event of a severe asthma episode, as described above.

Preferred hospital in case of emergency ______________________________

●I give permission for school personnel to release a copy of this Action Plan to emergency personnel in the event it is necessary to transport my child to the hospital.

●I authorize school personnel to implement this management and emergency plan as described above.

______________________________ ______________________________

Parent/Guardian's Signature Date

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