Ohio Department of Health

ASTHMA PROGRAM

# Two-way Asthma-Related Communication Form for Healthcare Providers and Schools

Date (mm/dd/yyyy): _____

Student name: _____ DOB (mm/dd/yyyy): _____

Parent/Guardian: _____

Dear _____, this student was seen in the school health office for problems with his/her asthma.

**The following is a brief summary of school nurse observations:**

**Presenting symptoms:**

☐ Cough ☐ Tight Chest ☐ Wheeze ☐ SOB ☐ Respiratory Rate _____

☐ Acute respiratory distress ☐ Other _____

**Precipitating factors:**

☐ Cold/virus ☐ Exercise or periods of activity ☐ Cold air

☐ Reports not taking daily long-term control medicine regularly

☐ No medication for the student at school

☐ Trigger/irritant/allergen exposure (specify):_____

☐ School absences this academic year due to asthma # _____

☐ EMS run for asthma

☐ Other: _____

**Medication:**

☐ Excessive use of quick-relief medicine

☐ Reports not taking daily long-term control medicine regularly

☐ Reports not having a spacer for ☐ home or ☐ school

☐ No medicine is at school/clinic

☐ Other: _____

**Additional School Nurse Notes:**

**School nurse assessment:**

**To support this student's asthma management at school, please send, order, or arrange:**

- ☐ A medical evaluation of this child
- ☐ A current Asthma Action Plan signed by the healthcare provider
- ☐ Rescue medication for school
- ☐ Assess the need for or adjustment of controller medications
- ☐ Spacer for school
- ☐ Referral for: _____
- ☐ Other: _____

**School nurse name: _____ Date**(mm/dd/yyyy)**: _____**

**Phone number: _____ Email: _____**

**Address: _____**

**Fax: _____**

**Healthcare provider plan**:

- ☐ Clinic will contact family to schedule an asthma check-up/ evaluation
- ☐ See attached new or revised Asthma Action Plan
- ☐ Continue with current Asthma Action Plan
- ☐ Medication order/refill called to pharmacy on record
- ☐ Spacer order called in to pharmacy on record
- ☐ Referred to: _____
- ☐ Other: _____

**Additional Healthcare Provider Notes:**

**Healthcare provider name: _____**

**Healthcare provider signature: _____**

**Date** (mm/dd/yyyy)**: _____**

**School nurses:** If you'd like to request spacers from the ODH Asthma Program, please fill out this form.