

Sample Case Management Form

(pg 1 of 1)



Student _____ School _____

Date of Birth _____ Today's Date _____

Gender: _____ Race: _____ Date of Asthma Action Plan: _____

Primary Health Care Provider: _____ Allergist / Pulmonologist: _____

First Severity Assessment Date ___/___/___
 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: _____

Enrolled in a special asthma program through health insurance? Yes No Don't know

Current Treatment	Check Which Applies	At School	At Home	None	Don't Know
Control medication at home or school: <small>(e.g., inhaled steroids, leukotriene modifier, cromolyn)</small> <input type="radio"/> Yes <input type="radio"/> No	Quick relief Rx (e.g. albuterol):				N/A
	Self-carry:				N/A
	Peak flow:				N/A
	Spacer:				N/A
	Nebulizer:				N/A
	Flu/pneumonia vaccine:				
Receiving allergy shots:					

Interventions done through school	Yes	No
Permission to interact with doctor		
Sent letter/called doctor		
Teach inhaler/spacer technique		
Teach peak flow technique		
Parent counseling 1:1		
Student health counseling 1:1		
Peak flow logs		
Asthma education for classmates		
Open airways for schools received		
Other classroom education curriculum received		
Parent or student support group		
Emergency protocol on file		
Emergency protocol shared with staff		
P.E. teacher education		
Staff education/counseling If yes, # of staff: _____		
Trigger identification at school		
Trigger modification at school		
Trigger identification at home		
Trigger modification at home		
Home visit relating to asthma		
Referral allergy shots		
Receiving allergy shots		
Enrolled in a special asthma program through health insurance		

Repeat Severity Assessment Date ___/___/___
 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: _____

Enrolled in a special asthma program through health insurance? Yes No Don't know

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	Self-carry:				N/A
	Peak flow:				N/A
	Spacer:				N/A
	Nebulizer:				N/A
	Flu/pneumonia vaccine:				
Receiving allergy shots:					

Asthma related school events (summary of all per school year)

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 Signature: _____