San Diego City Schools
Wellness Program

Date ______________________________

Dear ____ [name of provider]

Asthma may be affecting your patient's school performance.

We are writing about your patient, ________________________________ Birth date ____________________.

The following information is being provided for your information and records.

- ❒ Missed ________ days in __________ (period of time), possibly due to asthma.
- ❒ Is not complying with asthma medication at school or the treatment plan you have provided.
- ❒ Is not participating in P.E. because of symptoms related to asthma.
- ❒ Visits school health office frequently because of symptoms related to asthma.
- ❒ Has required emergency management of asthma (e.g.: 911, ER referral).
- ❒ Our history and observations reveal that this student's asthma severity has changed (see chart).

√	Please √ Appropriate Box	Days w Symptoms	Nights w symptoms	PEF variability
❑	Severe Persistent	*Continual*	*Frequent*	*> 30%*
❑	Moderate Persistent	*Daily*	*> 4 per month*	*> 30%*
❑	Mild Persistent	*> 2 per week*	*3 to 4 per month*	*20 – 30%*
❑	Mild Intermittent	*< 2 per week*	*< 2 per month*	*< 20%*

The family was asked to schedule an appointment with you. *Parents have provided permission for us to exchange information* (attached or shown below).

Please help with the following, either before or after the patient's next appointment:

- ❒ Please send us an "Asthma Action Plan" (attached form) so we can assist with your management plan.
- ❒ Student has no Peak Flow Meter. Please prescribe one so that we may better assist with management.
- ❒ Please prescribe a "Spacer." This student's technique with MDI was observed and is not adequate.
- ❒ Requires an additional MDI ______________ *(medication name)* at school for optimal availability/safety.
- ❒ Please reassess this child and his/her current medical regimen. (See symptoms/severity above.)
- ❒ Other ____

Please contact us if there are questions or concerns. Thank you!!

Sincerely,

____
School Nurse (Sign and Print)

____
District Medical Consultant

____
Wellness Program Manager

School: __________________ Ph: (____) ____________ Fax: (____) ______________ Best days/time:________

I permit my child's doctor (named above) to communicate with school staff regarding my child's asthma.

Parent's Signature ______________________________________ Date ____________________

HE 409
04/23/02