

San Diego City Schools
Wellness Program

Asthma Case Management Flow Sheet

Identifying Information

Date Initiated:	_____
Name:	_____
ID #:	_____
School:	_____
School Nurse:	_____
Health Care Provider(s):	_____
Permission to Contact Provider(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History

Asthma Diagnosis:	Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercised Induced
Severity Established by:	M.D.; School Nurse by HX
Known Allergies:	_____ _____
Asthma Diagnosis:	Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercised Induced
Severity established by:	M.D.; School Nurse by HX
Known Triggers:	Dust mites, molds, pollens, animal dander, feathers, cockroaches, cold, exercise, colds, sinus infections, cigarette smoke, chemicals, exhaust, foods, yelling, crying, laughing.
Other:	_____
Hospitalizations for Asthma:	_____
ED Visits for Asthma:	_____
911 Calls for Asthma:	_____
Total Days Absent:	_____
Days Absent Known to be due to Asthma:	_____
F/U Pneumonia Immunization:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Desensitization:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Nursing Interventions

District Absence Letter to Parent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
District Absence Letter to Physician	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Contact with SARB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Contact with CPS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Assistance with Insurance Enrollment, if none	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Home Visit Relating to Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Referral to Scamp Camp (Asthma Camp)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Referral to Asthma Education Program Through HMO or Provider	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Open Airways Program at School	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Referral to Asthma Support Group	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Trigger Identification at School	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Referral to Smoking Cessation Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Asthma Education and Emergency Procedures for Coach	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Parent Education and Counseling Regarding Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date (s) _____
Student Education and Counseling Regarding Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date (s) _____
Information to Parent Regarding Environmental Controls (HEPA filters, mattress covers, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Nebulizer at School	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____
Back-Up Inhaler in Health Office Even if Student Carries Inhaler	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date(s) _____

Current Assessment of Problem:

Date: _____
