

# School Nurse Respiratory Assessment

The information provided in this form is general and may not apply to every Student's situation. Check Student Asthma Action Plan provided by Parent/Guardian. Proceed accordingly.

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A Program of the  
American Respiratory Alliance  
of Western Pennsylvania

AM  PM  
 / /  
 TODAY'S DATE      TIME OF REPORT      NAME OF SCHOOL NURSE

Male  Female /  
 STUDENT'S NAME      AGE      GRADE

NAME OF SCHOOL      FAX NUMBER

MOST RECENT MEDICATION

AM  PM      / /       Don't know  
 DOSE      TIME      DATE

Yes  No  
 STUDENT USES SPACER

Unable to obtain  
 STUDENT'S PERSONAL BEST PEAK FLOW      STUDENT'S PRESENT PEAK FLOW READING

## ASTHMA ASSESSMENT – INTERVENTION – TREATMENT INCLUDES:

Quick-acting bronchodilator / Proper positioning / Breathing control / Relaxation

### NON-EMERGENCY EPISODE:

#### 1. CONSIDER non-medical treatment:

comfortable position, cool room, triggers removed, and hydration provided.

#### 2. OBSERVE/ASSESS/RECORD:

face, skin color, body, auscultation, breathing pattern/rate, pulse, and peak flow.

TIME: \_\_\_\_\_  AM  PM

- |  |  |
|--|--|
| <input type="checkbox"/> Chest tightness / discomfort                    | <input type="checkbox"/> Dyspnea/Respiratory rate _____                    |
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Retractions                                       |
| <input type="checkbox"/> Stooped body posture                            | <input type="checkbox"/> Nasal flaring                                     |
| <input type="checkbox"/> Cough   | <input type="checkbox"/> Pulse _____/minute                                |
| <input type="checkbox"/> Wheezing:                                       | <input type="checkbox"/> Peak Flow Meter result _____                      |
| <input type="checkbox"/> Inspiration <input type="checkbox"/> Expiration | <input type="checkbox"/> Decreased <input type="checkbox"/> Unable to test |

Medication Administered \_\_\_\_\_

Effectiveness:  Excellent  Good  Poor

Outcome:  Home  Back to class

#### 3. RE-ASSESS in 15–20 minutes

TIME: \_\_\_\_\_  AM  PM

- |   |  |
|---|--|
| <input type="checkbox"/> Cyanosis – <b>GO TO EMERGENCY ALERT on reverse side!</b> | <input type="checkbox"/> Dyspnea/Respiratory rate _____                    |
| <input type="checkbox"/> Chest tightness / discomfort                             | <input type="checkbox"/> Retractions                                       |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Nasal flaring                                     |
| <input type="checkbox"/> Stooped body posture                                     | <input type="checkbox"/> Pulse _____/minute                                |
| <input type="checkbox"/> Cough  | <input type="checkbox"/> Peak Flow Meter result _____                      |
| <input type="checkbox"/> Wheezing:  | <input type="checkbox"/> Decreased <input type="checkbox"/> Unable to test |
| <input type="checkbox"/> Inspiration <input type="checkbox"/> Expiration          |  |

Medication Administered \_\_\_\_\_

Effectiveness:  Excellent  Good  Poor

Outcome:  Ambulance  Home  Back to class

