



San Diego Unified School District

STUDENT SERVICES OFFICE
2351 Cardinal Lane, Annex B, San Diego, CA 92123-3743

(858) 627-7580
Fax: (858) 627-7444

Nursing and Wellness Program

Date: _____

Dear: _____ [name of student's health care provider]

We are writing about your patient, _____ Date of Birth: _____

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 (eg: 911, ER referral).
- Our history and observations reveal that this student's asthma severity has changed (see chart).

(Nurse, check one below)	<u>Days w Symptoms</u>	<u>Nights w symptoms</u>
<input type="checkbox"/> Severe Persistent	<i>Continual</i>	<i>Frequent</i>
<input type="checkbox"/> Moderate Persistent	<i>Daily</i>	<i>> 4 per month</i>
<input type="checkbox"/> Mild Persistent	<i>> 2 per week</i>	<i>3 to 4 per month</i>
<input type="checkbox"/> Mild Intermittent	<i>< 2 per week</i>	<i>< 2 per month</i>

The family was asked to schedule an appointment with you.

- A signed parent consent form to exchange information with the school is attached
- An unsigned parent consent form to exchange information with the school is attached. Please ask parent to sign this at the visit.

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 (Printed and Signed)

School: _____ Ph: (____) _____ Fax: (____) _____ Best days/time: _____

HIPPA Compliant Release of Information attached: Yes No