Bronchial asthma is a chronic pulmonary disorder, frequently allergic in nature, and characterized by paroxysms of dyspnea, wheezing, tightness in the chest, and bronchospasm. Asthmatic attacks may be minor and short in duration with little discomfort, or they may be very severe and of long duration, producing the characteristic picture of intractability. During symptomatic periods, it is usually possible to demonstrate changes in certain aspects of pulmonary function. With mild symptoms or between the episodes of severe asthma, the individual may be at little or no disadvantage in any or all activities. However, when the symptoms of pulmonary distress become severe or prolonged, this may lead to interruption of the child's daily routine, including school attendance. Occasionally, such children may become home or hospital bound for long periods of time.

Between the two extremes of no symptoms and severe asthma, there is a spectrum of respiratory or pulmonary disability—the nature and severity of which requires that each child receive individual consideration and evaluation in the matter of his daily activity. The outlook for the control of asthma in children has been improving during the past several decades. However, with the increase in population, there is an increasing number of children who require medical management for this disorder. It is a leading medical cause for school absenteeism and probably contributes to inefficient school work because of chronic fatigue, irritability, decreased attention span, and secondary emotional disorders.

There is general agreement among physicians that most children with bronchial asthma should attend regular school since, when under proper control and with no residual pulmonary defect, the child needs no special facilities. However, in certain instances, special environmental facilities for rest periods, drugs, and so forth may be needed.

Both physical and mental activities are useful to asthmatic children. The majority of asthmatic children can participate in physical activities at school and in athletics with minimal difficulty, provided the asthma is under satisfactory control. Overfatigue and emotional upheaval in competitive athletic contests appear to be predisposing factors in precipitating asthmatic attacks in some instances. This may depend to some extent on the duration and the severity of the disease. As a general rule, every effort should be made to minimize restrictions and to invoke them only when the condition of the child makes it necessary.

With proper medical management, the majority of asthmatic children in school can participate in physical education. In severe asthmatic children, sports involving body contact should be prohibited. Noncontact sports (such as tennis) and gymnastics (such as rope climbing, parallel bars, and so forth) should be encouraged but should be evaluated on an individual basis for each asthmatic child, depending upon his tolerance for duration and intensity of effort. There is evidence that swimming can be helpful.

Periodic review of the health status of the asthmatic child should be made. Written records of annual and periodic health
evaluations by the pediatrician or family physician managing the asthma should be on file in the office of the school nurse or physician. Physicians who assume the responsibility for the medical care of asthmatic children can be of greater usefulness to their patients if they become familiar with the character of the physical education and athletic programs in the schools attended by them. It is desirable that medical evaluation of the asthmatic child with chronic or recurrent symptoms include an allergy survey performed by a competent allergist who is also knowledgeable about growth and development of children.

At the time when a decision is to be made to modify participation in school athletics, the physician managing the child should be involved.

In children with bronchial asthma, and many other chronic conditions, it is important that the patient and his family recognize early during the course of the disease that certain adjustments may be necessary in the daily routine. However, one must attain a balance between the needs of the child to participate in the activities with as little restriction and emotional crippling as possible and the necessary limitations to living a full life.

With proper balance in these matters and optimal management of the disease process, the child with a chronic illness such as asthma should be able to develop the self-confidence necessary to grow and develop in a satisfactory manner.

The Committee therefore recommends that any decision to modify a school athletic program for a child with asthma must be the joint responsibility of physician, child, parent, and school. Recommendations should be individualized. Caution should prevail in order to avoid giving the child a feeling of inferiority or of being different from other children.

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