Asthma History Form

Student Name: _____ Date of Birth: _____
Parent/Guardian: _____ Today's Date: _____
Home Phone: _____ Work: _____ Cell: _____
Primary Healthcare Provider: _____ Phone: _____
Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ❑ No ❑ Yes

2. History and Current Status

a. How severe is student's asthma

- ❑ Mild
- ❑ Moderate
- ❑ Severe

b. Age of student when asthma diagnosed: _____
c. How many times has student had an epsiode?
❑ Never ❑ Once ❑ More than once, explain:
_____
d. Explain their past episode(s) _____
e. Symptoms: _____

3. Trigger and Symptoms

a. What triggers student's asthma?

❑ Exercise ❑ Allergies ❑ Cold ❑ Illness ❑ Stress
❑ Other _____ ❑ Smoke (is student around anyone that smokes? YES/NO

b. How does your student communicate his/hear symptoms? _____

c. How quickly do symptoms appear after triggers? ____secs. ____mins. ___hrs. ____days

d. Please check student's usual symptoms during asthma attack?

- ❑ Tightness in chest
- ❑ Shortness of breath
- ❑ Cough
- ❑ Wheezing
- ❑ Other (please describe):_____

4. Treatment

a. What medications is your student currently using to control or treat asthma symptoms?

Name of Medicine	What is the dose?	When is it used?

b. If your student uses an inhaler, is a spacer used? ❑ No ❑ Yes
c. Does your student need medication at school? ❑ No ❑ Yes
* If yes, a *Medication Authorization Form* must be completed and returned to the school clinic with medication.

5. Self Care

a. Does student know when he/she needs medicine? ❑ No ❑ Yes

b. Does your student:

1. Know what activities to avoid ❑ No ❑ Yes
2. Tell an adult immediately if experiencing asthma episode ❑ No ❑ Yes
3. Wear a medical alert bracelet, necklace, watchband ❑ No ❑ Yes
4. Tell peers and adults about their asthma ❑ No ❑ Yes

c. Does your child know how to use emergency medication? ❑ No ❑ Yes _____

d. Has your child ever administered their own emergency medication? ❑ No ❑ Yes _____

6. Family / Home

a. How do you feel that the whole family is coping with your student's asthma reaction? _____

b. Does your child carry an inhaler in the event of an episode? ❑ No ❑ Yes

c. Has your child ever needed to administer their inhaler? ❑ No ❑ Yes

d. Do you feel that your child needs assistance in coping with his/her asthma? _____

7. General Health

a. How is your child's general health other than having asthma? _____

b. Does your child have other health conditions? _____

c. Hospitalizations? _____

d. Please add anything else you would like the school to know about your child's health: _____

_____

_____

8. Notes:

_____

_____

_____

_____

_____

_____

Parent / Guardian Signature: _____ **Date:** _____

Parent #: _____

Reviewed by R.N.: _____ **Date:** _____