

School Year: _____ - _____



Parent Form - Asthma History

Student's Name: _____ Date of Birth _____

School _____ Grade/Teacher _____

Please provide the following information:

1. Name of medical provider treating your child's asthma: _____
2. Does your child have health concerns other than asthma? _____
3. When was this student's asthma first diagnosed? _____
4. How many times has student been seen in the emergency room for asthma in the past year? _____
5. How many times has this student been hospitalized for asthma in the past year? _____
6. Has this student ever been admitted to an intensive care unit for asthma? _____ When? _____

7. How would you rate the severity of this student's asthma? (please circle number below)

(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

8. How many days would you estimate this student missed last year because of asthma? _____

9. What triggers this student's asthma? (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Respiratory infection | <input type="checkbox"/> Carpets |
| <input type="checkbox"/> Cigarette smoke | <input type="checkbox"/> Stress | <input type="checkbox"/> Molds |
| <input type="checkbox"/> Wood smoke | <input type="checkbox"/> Chalk dust | <input type="checkbox"/> Temperature changes |
| <input type="checkbox"/> Pollen | <input type="checkbox"/> Indoor dust | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Outdoor dust | |
| <input type="checkbox"/> Animals (specify): _____ | <input type="checkbox"/> Foods (specify): _____ | |

10. What does this student do at home to relieve asthma symptoms? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Breathing exercises | <input type="checkbox"/> Takes medications (see below) |
| <input type="checkbox"/> Drinks liquids | <input type="checkbox"/> Uses herbal remedies (see below) |
| <input type="checkbox"/> Rest/relaxation | <input type="checkbox"/> Other: _____ |

11. Control of School Environment: List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode: _____

12. What medication does this student take for asthma (every day and as needed):

Name of Medication	Amount	Delivery Method (nebulizer, inhaler, etc.)	How Often

10. What herbal remedies, if any, does this student take for asthma? _____

11. Does this student use any of the following aids for managing asthma?

- Holding chamber/Spacer
- Holding chamber/Spacer with mask
- Peak flow meter (personal best _____)
- Other: _____

12. Please check special needs related to your child's asthma:

- Physical education class
- Avoidance of certain foods
- Transportation
- Observation of side effects
- Recess
- Field trips
- Animals in classroom
- Access to water
- Other: _____

13. If you checked any of the above, please describe needs: _____

Parent/Guardian Signature: _____ Date: _____

Reviewed by school nurse: _____ Date: _____