School Year: _____ - _____

RICHLAND School District

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)

☐ Exercise ☐ Respiratory infection ☐ Carpets
☐ Cigarette smoke ☐ Stress ☐ Molds
☐ Wood smoke ☐ Chalk dust ☐ Temperature changes
☐ Pollen ☐ Indoor dust ☐ Other: _____
☐ Strong odors or fumes ☐ Outdoor dust
☐ Animals (specify): _____ ☐ Foods (specify): _____

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

☐ Breathing exercises ☐ Takes medications (see below)
☐ Drinks liquids ☐ Uses herbal remedies (see below)
☐ Rest/relaxation ☐ 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: _____