

Student: \_\_\_\_\_ Grade: \_\_\_\_ Birthdate: \_\_\_\_\_ School: \_\_\_\_\_

*The following information is helpful to the nurse in determining any special needs for your child at school. Please answer the questions to the best of your ability and return this form to your school nurse.*

**ASTHMA HISTORY**

- How long has your student had asthma? \_\_\_\_\_ When diagnosed? \_\_\_\_\_
- Has your student **ever** experienced or had a history of:
  - Sudden severe asthma attacks?  NO  YES
  - 911 called due to asthma symptoms?  NO  YES
  - Prior intubation/mechanical ventilation?  NO  YES
  - Prior admission to an ICU?  NO  YES
  - Prior admission to a hospital?  NO  YES
  - Use of oral steroids?  NO  YES
 \*If YES to any above, please explain: \_\_\_\_\_
- Has your student been seen by a specialist for asthma or allergies?  NO  YES
- Allergy testing done?  NO  YES When? \_\_\_\_\_ Positive allergens? \_\_\_\_\_

**ASTHMA PROFILE**

- SEVERITY: Check appropriate box that describes your student's symptoms:

	Severity	Symptoms	Short-Acting Inhaler Use	Nighttime Symptoms
<input type="checkbox"/>	Mild Intermittent	<ul style="list-style-type: none"> <li>• 2 or fewer days per week</li> <li>• Do not interfere with normal activity</li> </ul>	2 or fewer days per week	2 or fewer times per month
<input type="checkbox"/>	Mild Persistent	<ul style="list-style-type: none"> <li>• &gt; 2 days per week but not daily</li> <li>• Minor limitations to normal activity</li> </ul>	> 2 days per week but not daily	3 - 4 times per month
<input type="checkbox"/>	Moderate Persistent	<ul style="list-style-type: none"> <li>• Daily symptoms</li> <li>• Some limitation to normal activity</li> </ul>	Daily	> 1 time per week, but not nightly
<input type="checkbox"/>	Severe Persistent	<ul style="list-style-type: none"> <li>• Throughout the day</li> <li>• Extreme limitation to normal activity</li> </ul>	Several times per day	Often, sometimes every night

- In the **past 1 year**, how many times has your student been:
 

	NONE	ONCE	2-4	>4
• Hospitalized overnight or longer for asthma:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Treated in an emergency room:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Treated in a doctor's office for non-routine asthma:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Prescribed steroids for asthma exacerbation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- CAUSES: (check all that apply)

<input type="checkbox"/> Exercise <input type="checkbox"/> *My student's asthma is exercise-induced ONLY <input type="checkbox"/> Allergen: <input type="checkbox"/> dust mites <input type="checkbox"/> pollen <input type="checkbox"/> grass <input type="checkbox"/> trees <input type="checkbox"/> mold <input type="checkbox"/> pet dander <input type="checkbox"/> foods: _____	<input type="checkbox"/> Respiratory infections <input type="checkbox"/> Weather: <input type="checkbox"/> cold air <input type="checkbox"/> changes in weather <input type="checkbox"/> Strong emotions <input type="checkbox"/> Stress <input type="checkbox"/> Laughing <input type="checkbox"/> Other: _____
<input type="checkbox"/> Air Irritants: <input type="checkbox"/> cigarette smoke <input type="checkbox"/> air pollution <input type="checkbox"/> dust <input type="checkbox"/> wildfire smoke <input type="checkbox"/> strong odors/vapors/fragrances	

- SYMPTOMS: (check all that apply)

**Early symptoms:**

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> cough                      | <input type="checkbox"/> persistent cough  | <input type="checkbox"/> wheeze            | <input type="checkbox"/> decreased exercise | <input type="checkbox"/> short of breath |
| <input type="checkbox"/> tightness in chest         | <input type="checkbox"/> itchy watery eyes | <input type="checkbox"/> itchy throat/chin | <input type="checkbox"/> stuffy/runny nose  | <input type="checkbox"/> irritability    |
| <input type="checkbox"/> decreased appetite         | <input type="checkbox"/> fatigue           | <input type="checkbox"/> headache          | <input type="checkbox"/> stomachache        | <input type="checkbox"/> behavior change |
| <input type="checkbox"/> decreased peak flow: _____ |  | <input type="checkbox"/> other: _____      |   |  |

**Severe symptoms:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> short of breath | <input type="checkbox"/> incessant coughing | <input type="checkbox"/> vomit from coughing            | <input type="checkbox"/> wheeze with in/out breath     |
| <input type="checkbox"/> rapid breathing | <input type="checkbox"/> tightness in chest | <input type="checkbox"/> pull in of chest /neck muscles | <input type="checkbox"/> can't speak in full sentences |
| <input type="checkbox"/> nasal flaring   | <input type="checkbox"/> anxious/scared     | <input type="checkbox"/> sweating/clammy skin           | <input type="checkbox"/> skin color change             |
| <input type="checkbox"/> fatigue         | <input type="checkbox"/> spitting up mucus  | <input type="checkbox"/> decreased peak flow: _____     | <input type="checkbox"/> other: _____                  |



**ASTHMA IMPACT (answer based on the past 1 year)**

9. How often does your student have symptoms?: Daytime: \_\_\_\_\_ times/wk Nighttime: \_\_\_\_\_ times/wk  
 10. Is your student's sleep interrupted by asthma symptoms?  NO  YES  
 11. Does your student limit or modify physical activity due to asthma?  NO  YES, Explain: \_\_\_\_\_

**ASTHMA TREATMENT & MANAGEMENT**

12. What does your student do at home to manage asthma symptoms (check all that apply):  
 medication  rest/relax  drink liquids  breathing exercises  herbal remedies  other: \_\_\_\_\_

13. **Medication & Treatment Plan:** Please list ALL medication your student takes **for asthma and allergies**

Medication Name	Dosage	Time	Indications to Take	Where Taken
		<input type="checkbox"/> Daily (Time: _____) <input type="checkbox"/> As Needed		<input type="checkbox"/> Home <input type="checkbox"/> School*
		<input type="checkbox"/> Daily (Time: _____) <input type="checkbox"/> As Needed		<input type="checkbox"/> Home <input type="checkbox"/> School*
		<input type="checkbox"/> Daily (Time: _____) <input type="checkbox"/> As Needed		<input type="checkbox"/> Home <input type="checkbox"/> School*

*\*Any medication kept at school requires a separate medication authorization signed by a healthcare provider and parent.*

14. Typically, how often does your student use a rescue inhaler (i.e. Albuterol)?  
 Daytime: \_\_\_\_\_ per week Nighttime: \_\_\_\_\_ per week  
 15. When was the last time your student used a rescue inhaler (i.e. Albuterol)? \_\_\_\_\_  
 16. If your student has exercise-induced asthma, do they use an inhaler before exercise?  NO  YES  N/A  
 17. Does your student use a Peak Flow Meter?  NO  YES

**SCHOOL PLANNING**

18. Will you provide medication to keep at school?  NO  YES \* *requires medication order signed by healthcare provider.*  
 19. Will you provide any of the following for school?  spacer  nebulizer  peak flow  disaster meds/supplies  
 20. What is your student's independence level in taking their medication?  
 completely independent  self-administration with adult supervision  adult gives medication  
 21. Are you planning for your student to self-carry a rescue inhaler at school?  NO  YES \*  
*\*Final decision depends on developmental level of student and approval by nurse, healthcare provider, and parent.*  
 22. Can your student identify when they have asthma symptoms and need medication/help?  NO  YES  
 23. Control of School Environment (check each that applies to the need of your student):  
 Modified recess or PE\*  Pre-medicate for exercise\*  Observe for side effects of medication  
 Free access to water  Avoid certain food  Special transportation to/from school\*  
 Avoid animals at school  Avoid strong odors  Need special field trip planning  
*\*Requires a note from a healthcare provider*

24. Is your student involved in after school sports/activities?  NO  YES \*, which one?: \_\_\_\_\_  
*\* Parent must inform adult of student's condition. \*Non-school-sponsored activities require separate medication provided by parent.*

**CARE COORDINATION**

25. Which healthcare provider is currently managing your student's asthma? \_\_\_\_\_  
 26. Does your student have health insurance?  NO  YES, which one? \_\_\_\_\_  
 27. Are you having any challenges getting asthma medication or connecting with a doctor?  NO  YES

 \_\_\_\_\_  
**Parent/Guardian Signature & Relationship**

 \_\_\_\_\_  
**Date**

 \_\_\_\_\_  
**Email address**