Edmonds School District

HS 26
Student Health Services
Asthma Information Form - Initial

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

1. How long has your student had asthma? _____ When diagnosed? _____
2. 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: _____
3. Has your student been seen by a specialist for asthma or allergies? ☐ NO ☐ YES
4. Allergy testing done? ☐ NO ☐ YES When? _____ Positive allergens? _____

ASTHMA PROFILE

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

	Severity	Symptoms	Short-Acting Inhaler Use	Nighttime Symptoms
☐	Mild Intermittent	• 2 or fewer days per week • Do not interfere with normal activity	2 or fewer days per week	2 or fewer times per month
☐	Mild Persistent	• > 2 days per week but not daily • Minor limitations to normal activity	> 2 days per week but not daily	3 - 4 times per month
☐	Moderate Persistent	• Daily symptoms • Some limitation to normal activity	Daily	> 1 time per week, but not nightly
☐	Severe Persistent	• Throughout the day • Extreme limitation to normal activity	Several times per day	Often, sometimes every night

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

	NONE	ONCE	2-4	>4
• Hospitalized overnight or longer for asthma:	☐	☐	☐	☐
• Treated in an emergency room:	☐	☐	☐	☐
• Treated in a doctor's office for non-routine asthma:	☐	☐	☐	☐
• Prescribed steroids for asthma exacerbation:	☐	☐	☐	☐

7. CAUSES: (*check all that apply*)

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

8. SYMPTOMS: (*check all that apply*)

Early symptoms:

☐ cough	☐ persistent cough	☐ wheeze	☐ decreased exercise	☐ short of breath
☐ tightness in chest	☐ itchy watery eyes	☐ itchy throat/chin	☐ stuffy/runny nose	☐ irritability
☐ decreased appetite	☐ fatigue	☐ headache	☐ stomachache	☐ behavior change
☐ decreased peak flow: _____		☐ other: _____		

Severe symptoms:

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

OVER

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
		☐Daily (Time:_____)☐As Needed		☐Home ☐School*
		☐Daily (Time:_____)☐As Needed		☐Home ☐School*
		☐Daily (Time:_____)☐As Needed		☐Home ☐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***