SUMNER SCHOOL DISTRICT
A GREAT PLACE TO LEARN.

ASTHMA HISTORY FORM

Student and Contact Information

Student Name:		Today's Date:	Date of Birth:
Parent/Guardian Name:	Preferred Phone (home/cell/work?)	Alternate Phone (home/cell/work?)	
Alternate Contact Name:	Preferred Phone (home/cell/work?)	Alternate Phone (home/cell/work?)	
Primary Health Care Provider/Organization:	Phone	Preferred Hospital:	

Asthma Information

First Diagnosis Date:	Emergency Room Visits for Asthma in Past Year (#):	Hospitalizations for Asthma in Past Year (#):	**Ever** Admitted to Intensive Care Unit? **Yes / No** If yes, list date(s):

Rate Severity: **1 2 3 4 5 6 7 8 9 10**
(not severe) (severe)

Estimated Number of School Days Missed Last Year:

Asthma Triggers

☐ exercise ☐ stress ☐ respiratory infections ☐ temperature changes	☐ indoor dust ☐ outdoor dust ☐ chalk dust ☐ carpets ☐ scents ☐ fumes/odors	☐ cigarette smoke ☐ wood smoke ☐ mold ☐ pollen	☐ foods (specify): ☐ animals (specify): ☐ other (specify):

Symptom Relievers

☐ breathing exercises	☐ rest/relax	☐ drink liquids	☐ take medications	☐ use herbal remedies	☐ other (specify):

Medications

All Current Medications (for all conditions, daily and as needed):

Medication Name	Method	Amount	Schedule

Life Threatening Allergies

Student has an **EpiPen** ordered/prescribed for a life-threatening allergy: **Yes / No**

If yes, list allergens:

See next page/side

Herbal/Natural Remedies

All Current Herbal/Natural Remedies (for all conditions, daily and as needed):

Remedy Name	Method	Amount	Schedule
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Aids

Aids student uses for asthma management:

☐ peak flow meter	personal best:	☐ peak flow meter will be provided for school
☐ holding chamber	☐ spacer	☐ holding chamber with mask
☐ other (specify):		

Special Considerations/Needs

Check student's special considerations/needs regarding asthma:

☐ physical education class	☐ recess	☐ transportation to/from school
☐ animals in classroom	☐ access to water	☐ avoidance of certain foods
☐ field trips	☐ observation of side effects from medications	
☐ other (specify):		

If you checked any of the boxes above, please describe considerations/needs:

Student has received asthma education: **Yes** / **No**

Asthma education requested for : **Student** / **Parent/ Guardian**

Notes

Signatures

Parent/Guardian Signature:	Date:
Nurse Signature:	Date:

Please complete and return to school Health Room