ASTHMA INFORMATION FORM

Student's Name ___________________________ Birthdate ___________________________

School ___________________________ Grade ___________ Class (home) room ___________

The following information is helpful to the nurse and school staff in determining any special needs for your child. If you desire a conference with the school nurse, please call for an appointment. Thank you for your assistance.

School Nurse ___________________________ Phone ___________________________

Please indicate which best describes your child’s asthma:

☐ Asthma is no longer a health concern for my child.

☐ Asthma is a health concern for my child but is stable and does not require medication at school.

☐ Asthma is a health concern and requires medication at school. A School Asthma Plan will be required before student is able to attend school.

1. How long has your child had asthma?__________

2. Medications taken at home: ___________________________

3. Medications taken during school (as needed medication): ___________________________

4. Check a box below that most accurately describes the current severity of your child's asthma.

<table>
<thead>
<tr>
<th>Severity of Asthma</th>
<th>Symptoms</th>
<th>Nighttime Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Mild intermittent</td>
<td>Two or fewer times a week; no symptoms between episodes; brief episodes from a few hours to a few days and vary in intensity.</td>
<td>Two or fewer times a month</td>
</tr>
<tr>
<td>□ Mild persistent</td>
<td>Symptoms more than twice a week but less than once a day. Episodes may affect activity.</td>
<td>More than twice a month</td>
</tr>
<tr>
<td>□ Moderate persistent</td>
<td>Daily symptoms; daily use of short-acting inhalers. Episodes affect activity and occur at least twice a week and may last days</td>
<td>More than once a week</td>
</tr>
<tr>
<td>□ Severe persistent</td>
<td>Continual symptoms; limited physical activity; frequent episodes</td>
<td>Frequent</td>
</tr>
</tbody>
</table>

Please indicate what triggers your child’s asthma: □ Respiratory infection □ Emotions / stress □ Chemical odors □ Foods □ Weather changes

Please indicate your child’s early warning signs:

□ Cough □ Cold symptoms □ Drop in peak flow □ Wheezing □ Decreased exercise □ Other (list) __________

Please check all special considerations related to your child’s asthma that he/she will need while at school:

□ None □ Avoiding strong smelling chemicals or irritants (chalk dust, sawdust, paint) □ Modified recess or gym class *Note from physician required □ Avoiding certain foods: ___________________________

□ Special considerations while on field trips □ Special transportation to and from school* *Note from physician recommended □ Avoiding animals/pets □ Other ___________________________

Parent/Guardian Signature: ___________________________ Date: ___________________________