Edmonds School District

HS-28
Student Health Services
Asthma Information Form - Annual Update

Student: _____ Grade: _____ Birthdate: _____ School: _____

The purpose of this form is to get an UPDATE on your student's asthma. Please answer to the best of your ability and return this form to your school nurse.

1. Has your student had any asthma exacerbations this year? (i.e. symptoms not managed at home, hospitalizations, 911 calls, etc.) ❑ No ❑ Yes, please explain: _____

_____

_____

2. Has anything changed with your student's asthma in the past year? (i.e. causes or symptoms, health care providers, new mediation, etc.) ❑ No ❑ Yes, please explain: _____

_____

_____

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

	None	Once	2-4	>4
a. Hospitalized overnight or longer for asthma:	❑	❑	❑	❑
b. Treated in an emergency room:	❑	❑	❑	❑
c. Treated in a doctor's office for non-routine asthma:	❑	❑	❑	❑
d. Prescribed steroids for asthma exacerbation:	❑	❑	❑	❑

*If more than none, please explain: _____

_____

_____

4. Current 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:_____

5. Have there been any changes to your student's typical asthma symptoms? ❑ No ❑ Yes, describe: _____

_____

Asthma Impact (in past 1 year)

6. How often does your student have: Daytime symptoms: _____ times/week
   Nighttime symptoms: _____ times/week

7. Is your student's sleep interrupted by asthma symptoms? ❑ No ❑ Yes

8. Does your student limit or modify physical activity due to asthma? ❑ No ❑ Yes, explain: _____

_____

Asthma Treatment & Management

9. Please list all current medication your student takes for ***asthma and allergies***: _____

_____

10. Typically, how often does your student use a rescue inhaler (i.e. Albuterol)? Daytime: _____ per week
    Nighttime: _____ per week

11. When was the last time your student used a rescue inhaler (i.e. Albuterol)? _____

12. If your student has exercise-induced asthma, are they using an inhaler before exercise? ❑ N/A ❑ No ❑ Yes

School Planning *(if you receive this form at end-of year, complete with next school year in mind)*

13. Will you be providing medication to be kept at school? ❑ No ❑ Yes *
    New medication authorization form signed by a healthcare provider and parent is required each school year.

14. 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.

15. Control of School Environment (check each that applies to the need of your students):
    ❑ 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

16. Will your student be 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

17. Which healthcare provider is currently managing your student's asthma? _____

18. Does your student have health insurance? ❑ No ❑ Yes, which one? _____

19. Are you having any challenges getting asthma medication or connecting with a doctor? ❑ No ❑ Yes: _____
    _____

_____ _____ _____

Parent/Guardian Signature & Relationship ***Date*** ***Email***