Lorain City Schools

Date_____

Information about your Asthma

All students (parent of student) with asthma please complete this form and give it to your doctor.

Student's Name:_____Birth Date_____School_____

Grade_____Homeroom #_____

	Home	School	
A ACTIVITIES. Since the last visit, has the patient's asthma interfered with being physically active at home or at school (play, physical education) or in other activities?	( ) YES	( ) YES	N,N
S SLEEP. Since the last visit, has the patient's sleep been disturbed by having trouble breathing or coughing?	( ) YES		N
T TRIGGERS. Circle triggers (below) that seem to worsen the patient's asthma: Pet animals Feathers Birds Cigarette smoke Perfume Dust Mold Chalk Are triggers present at home/school?	( ) YES	( ) YES	N,N
H HAVING EQUIPMENT HANDY. (a) What asthma equipment do you have for use at home or school: Inhaler	( ) YES	( ) YES	Y,Y
Peak flow meter	( ) YES	( ) YES	Y,Y
Spacer	( ) YES	( ) YES	Y,Y
(b) Is rescue inhaler readily available for problems (easy access in school office or self-carry for teens)?	( ) YES	( ) YES	Y,Y
(c) How long does one inhaler last, on average? _____weeks	___times in 2 weeks	___times in 2 weeks	
(d) During the past 2 weeks, how often did the patient use their quick-relief inhaler?			
M MANAGEMENT PLAN. (a) Do you have a written Asthma Management Plan at home? At school?	( ) YES	( ) YES	Y,Y
(b) Do you think the written plan you have for home/school is now out-dated?	( ) YES	( ) YES	Y,Y
A ATTENDANCE. How many school days (or child daycare days) did the patient miss in the past two months because of asthma?		_____ days	

Completed by_____ Date_____

Is there new information since the last time you completed this form?

Name of school: _____

Name of school nurse or other health representative:_____ ( ) Do not know

Telephone number of school: _____( ) Do not know