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 #_____

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?	**Home** ( ) YES	**School** ( ) YES	N,N
S SLEEP. Since the last visit, has the patient's sleep been disturbed by having trouble breathing or coughing?	**Home** ( ) 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?	**Home** ( ) YES	**School** ( ) YES	N,N
H HAVING EQUIPMENT HANDY. (a) What asthma equipment do you have for use at home or school: Inhaler Peak flow meter Spacer (b) Is rescue inhaler readily available for problems (easy access in school office or self-carry for teens)? (c) How long does one inhaler last, on average? _____weeks (d) During the past 2 weeks, how often did the patient use their quick-relief inhaler?	**Home** ( ) YES ( ) YES ( ) YES ( ) YES ___times in 2 weeks	**School** ( ) YES ( ) YES ( ) YES ( ) YES ___times in 2 weeks	Y,Y Y,Y Y,Y Y,Y
M MANAGEMENT PLAN. (a) Do you have a written Asthma Management Plan at home? At school? (b) Do you think the written plan you have for home/school is now out-dated?	**Home** ( ) YES ( ) YES	**School** ( ) YES ( ) YES	Y,Y Y,Y
A ATTENDANCE. How many school days (or child daycare days) did the patient miss in the past two months because of asthma?		**School** _____ 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

A form that permits school and health care provider to exchange information must accomany this form.