MEAD SCHOOL DISTRICT

HEALTH SERVICES
2323 E. Farwell Rd • Mead WA 99021 • Telephone (509) 465-6000 • Fax (509) 465-6020

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. *(If previously Indicated for school, a doctor's note is needed to discontinue the plan)*
☐ Asthma is a health concern for my child but is **stable** and **does not require medication at school**. *(If previously Indicated for school, a doctor's note is needed to discontinue the plan)*
☐ Asthma is **a health concern** and **requires medication at school**. **A School Asthma Plan will be required <u>before</u> 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.**

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

Please indicate what triggers your child's asthma:		**Please indicate your child's early warning signs:**
☐ Respiratory infection	☐ Exercise	☐ Cough
☐ Emotions / stress	☐ Cigarette smoke	☐ Cold symptoms
☐ Chemical odors	☐ Medication	☐ Drop in peak flow
☐ Foods	☐ Allergies (list)_____	☐ Wheezing
☐ Weather changes	☐ Other (list) _____	☐ Decreased exercise
		☐ Other (list) _____

Please check all special considerations related to your child's asthma that he/she will need while at school:	
☐ None	☐ Special considerations while on field trips
☐ Avoiding strong smelling chemicals or irritants (chalk dust, sawdust, paint)	☐ Avoiding animals/pets
☐ Modified recess or gym class **Note from physician required*	☐ Other_____
☐ Avoiding certain foods:_____	_____

Parent/Guardian Signature: _____ **Date:** _____