ASTHMA ASSESSMENT FORM

HEALTH SERVICES
SCHOOL DISTRICT U-46

School Year:____________ Grade/Teacher:_____________
Student Name:______________________________ ID#:______________ Birthdate: _________
Address: ____
House Number / Street Apt # if necessary City ZIP

According to our records, your child has a history of a respiratory disorder. In order for school personnel to better understand his/her current status, please complete the following information. Also included is an Asthma Action Plan for the physician to complete at your next doctor visit.

PARENTS PLEASE COMPLETE THE FOLLOWING INFORMATION:

Diagnosis: _____________________________________Age or year of diagnosis ___________

Is your child still bothered by Respiratory Symptoms? ☐No ☐Yes

Parent/Guardian Name:____
Home Phone: ( )______________________
Mom Cell Phone ( )____________________Mom Work phone ( )______________________
Dad Cell Phone ( )_____________________Dad Work phone ( )______________________
Primary Physician Name: ____
Medical Group_______________________________________ Phone: ( )____________
Specialty Physician Name: ____
Medical Group_______________________________________ Phone: ( )____________

How often does your child see the physician for his/her Respiratory Symptoms? ____________
Has your child ever been hospitalized for Respiratory Symptoms? ☐No ☐Yes If yes, please explain:____

What triggers a Respiratory episode (check all that apply)?

☐ Food ☐ Allergies ☐ Infections ☐ Irritants ☐ Colds/Upper Respiratory Infection
☐ Drugs ☐ Exercise ☐ Animal dander ☐ Weather ☐ Other: ______________________

Please list all the medications your child takes at home and school for his/her diagnosis:

Name____________________ Dose _______________ Frequency _____________
Name_____________________ Dose ________________ Frequency _____________
Name_____________________ Dose ________________ Frequency _____________

Has your child been prescribed and given a **spacer** for use with his inhaler? ☐No ☐Yes

Does your child use a peak flow meter? ☐No ☐Yes Best Reading_________________
Will they need peak flow meter at school? ☐No ☐Yes (parent will provide) Frequency___________________

Does your child use oxygen? ☐ No ☐Yes Will they need oxygen at school? ☐ No ☐Yes

How often does your child have Respiratory symptoms during the **DAY**?

☐ 2 times or less per week ☐ Daily ☐ More than 2 times per week ☐ Continual

How often does your child have Respiratory symptoms during the **NIGHT**?

☐ 2 times or less per month ☐ 3-4 times a month ☐ 5 times or more per month ☐ Continual

I understand that it is my responsibility to keep my child's school personnel informed of changes in my child's medical condition and to immediately notify them and complete a new form if treatment for the condition is changed or modified in any way. I understand information is to be updated annually with each school year.
I give permission for the nurse to communicate as warranted with the physician regarding my child's health concerns.

Parent/Guardian
Signature:____
Month//Day / Year