Tidehaven Independent School District

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ASTHMA HISTORY FORM

Student's Name_____DOB_____Grade_____
Primary Healthcare Provider:_____Phone:_____

1. Has a healthcare provider diagnosed your child with asthma? Yes____ No____ At what age?___
   If yes, name of treating physician:_____
   Physician's phone #_____
2. Does your child have a Section 504 Plan for this health condition Yes____ No____
3. Has your child's asthma attacks/flares resulted in an emergency room visit or hospitalization?
   Yes____ No____ If yes, when_____
4. How often does your child have an asthma attack/flare?_____
5. When was the last attack/flare?_____
6. Has your child been prescribed medication for the treatment of asthma? Yes____ No____

List all medications prescribed for your child:

Medication Name	Dosage	Frequency	Will this medication be given at school? Yes/No

7. Will medication be provided for us to administer at school? Yes____ No____
   - If yes, list medication_____
8. What are the signs and symptoms of your child's asthma (coughing; wheezing; shortness of breath; chest tightness, pain or pressure, other)?
   _____
   _____
9. What are the early signs of your child's asthma?_____
10. What commonly triggers your child's asthma or makes it worse? (tobacco smoke, dust mites, pets, mold, outdoor air pollution, other)
    _____
    _____
11. How would you describe your child's level of independence managing his/her asthma at school including using an inhaler? ____Independent ____Needs supervision ____Full Assistance
    Comments:_____

Parent/Guardian Name:_____Date:_____
Parent/Guardian Signature:_____
Reviewed by Nurse: _____Date:_____