Chandler Unified School District #80

Asthma History

Student Name: ____DOB: ____________

School: _________________________Grade: ____________________Date: ______________

1. Has your child ever been diagnosed by a licensed healthcare provider with Asthma? ☐ No ☐ Yes
2. Approximately how often does your child have an asthma attack?

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3. When was the last asthma attack?

____

4. Does exercise cause an asthma attack? ☐ No ☐ Yes If yes, explain.

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5. Does weather affect your child's asthma? ☐ No ☐ Yes If yes, explain.

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6. What are your child's asthma symptoms?

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7. Will your child need the use of an asthma inhaler while in school? ☐ No ☐ Yes If yes, a **Consent for Medication Administration form must be on file. If the inhaler is to be carried by the student a Self-Carry Consent must be on file.**

8. List any other asthma medication(s) taken routinely, the dosage, and how often they are to be taken in school. Any medications taken at school must have a **Consent for Medication Administration form on file.**

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9. Does your child have side effects from the medication(s)? ☐ No ☐ Yes If yes, explain.

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10. Is there any other information about your child's condition you would like to share with school?

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Parent/Guardian Name (Print):_____________________________Phone No. _________________

Parent/ Guardian Signature: ________________________________Date: _____________________