

Student's Name: _____ Birthdate: _____ Grade: _____ School/School Year: _____

The following information is helpful to the nurse in determining any special needs for your child at school. Please answer the questions to the best of your ability and return this form to your school nurse.

ASTHMA/HEALTH HISTORY

- How long has your student had asthma? _____ When diagnosed? _____
- Has your student **ever** experienced or had a history of:

• Sudden severe asthma attacks? ☐ NO ☐ YES	• Prior admission to an ICU? ☐ NO ☐ YES
• 911 called due to asthma symptoms? ☐ NO ☐ YES	• Prior admission to a hospital? ☐ NO ☐ YES
• Prior intubation/mechanical ventilation? ☐ NO ☐ YES	• Use of oral steroids? ☐ NO ☐ YES

*If **YES** to any above, please explain: _____
- Has your student been seen by a specialist for asthma or allergies? ☐ NO ☐ YES
- Allergy testing done? ☐ NO ☐ YES, when? _____ Positive allergens? _____
- Besides asthma, are there any other medical conditions we should be aware of? ☐ No ☐ Yes (For example: anaphylaxis, allergies, heart, respiratory, mental health conditions) If so, please explain: _____

ASTHMA PROFILE

6. SEVERITY: Check appropriate box that describes your student's symptoms:

	Severity	Symptoms	Short-Acting Inhaler Use	Nighttime Symptoms
☐	Mild Intermittent	• 2 or fewer days per week • Do not interfere with normal activity	2 or fewer days per week	2 or fewer times per month
☐	Mild Persistent	• > 2 days per week but not daily • Minor limitations to normal activity	> 2 days per week but not daily	3 - 4 times per month
☐	Moderate Persistent	• Daily symptoms • Some limitation to normal activity	Daily	> 1 time per week, but not nightly
☐	Severe Persistent	• Throughout the day • Extreme limitation to normal activity	Several times per day	Often, sometimes every night

7. In the **past 1 year**, how many times has your student been:
- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | NONE | ONCE | 2-4 | >4 |
| • Hospitalized overnight or longer for asthma: | ☐ | ☐ | ☐ | ☐ |
| • Treated in an emergency room: | ☐ | ☐ | ☐ | ☐ |
| • Treated in a doctor's office for non-routine asthma: | ☐ | ☐ | ☐ | ☐ |
| • Prescribed steroids for asthma exacerbation: | ☐ | ☐ | ☐ | ☐ |
| • Absent from school for asthma-related symptoms: | ☐ | ☐ | ☐ | ☐ |

8. CAUSES: (check all that apply):

☐ Exercise ☐ *My student's asthma is exercise-induced ONLY	☐ Respiratory infections
☐ Allergen: ☐ Dust mites ☐ Pollen ☐ Grass ☐ Trees ☐ Mold	☐ Weather: ☐ Cold air ☐ Changes in weather
☐ Pet dander ☐ Foods:	☐ Strong emotions ☐ Stress ☐ Laughing
☐ Air Irritants: ☐ cigarette smoke ☐ Air pollution ☐ Dust	☐ Other: _____
☐ Wildfire smoke ☐ Strong odors/vapors/fragrances	

9. SYMPTOMS: (check all that apply)

Early symptoms:

- | | | | | |
|---|--|--|---|--|
| ☐ Cough | ☐ Persistent cough | ☐ Wheeze | ☐ Decreased exercise | ☐ Short of breath |
| ☐ Tightness in chest | ☐ Itchy watery eyes | ☐ Itchy throat/chin | ☐ Stuffy/runny nose | ☐ Irritability |
| ☐ Decreased appetite | ☐ Fatigue | ☐ Headache | ☐ Stomachache | ☐ Behavior change |
| ☐ Decreased peak flow: _____ | | ☐ Other: _____ | | |

Severe symptoms:

- ☐ Short of breath ☐ Incessant coughing ☐ Vomit from coughing ☐ Wheeze with in/out breath
☐ Rapid breathing ☐ Tightness in chest ☐ Pull in of chest /neck muscles ☐ Can't speak in full sentences
☐ Nasal flaring ☐ Anxious/scared ☐ Sweating/clammy skin ☐ Skin color change
☐ Fatigue ☐ Spitting up mucus ☐ Decreased peak flow: _____ ☐ Other: _____

ASTHMA IMPACT (answer based on the past 1 year)

10. How often does your student have symptoms? Daytime: _____ Times/Week Nighttime: _____ Times/Week
 11. Is your student's sleep interrupted by asthma symptoms? ☐ NO ☐ YES
 12. Does your student limit or modify physical activity due to asthma? ☐ NO ☐ YES, explain: _____

ASTHMA TREATMENT & MANAGEMENT

13. What does your student do at home to manage asthma symptoms (*check all that apply*):
☐ Medication ☐ Rest/relax ☐ Drink liquids ☐ Breathing exercises ☐ Herbal remedies ☐ Other: _____
 14. **Medication & Treatment Plan:** Please list ALL medication your student takes *for asthma and allergies*.

Medication Name	Dosage	Time	Reason	Where Taken
		☐ Daily (Time: _____) ☐ As Needed		☐ Home ☐ School*
		☐ Daily (Time: _____) ☐ As Needed		☐ Home ☐ School*
		☐ Daily (Time: _____) ☐ As Needed		☐ Home ☐ School*

***Any medication kept at school requires a separate medication authorization signed by a healthcare provider and parent.**

15. When was the last time your student used a rescue or "as needed" inhaler (i.e. Albuterol, Symbicort, Dulera)? What was the reason?

 16. Typically, how often does your student use a rescue or "as needed" inhaler (i.e. Albuterol, Symbicort, Dulera)?
 Daytime: _____ Per week Nighttime: _____ Per week
 17. If your student has exercise-induced asthma, do they use an inhaler before exercise (i.e. sports, recess, or PE)? ☐ NO ☐ YES ☐ N/A
☐ SOMETIMES, explain: _____
 18. Does your student use a Peak Flow Meter? ☐ NO ☐ YES

SCHOOL PLANNING

19. Has your student ever had a health plan at school for asthma? ☐ NO ☐ YES
 20. Will you provide medication to keep at school? ☐ NO ☐ YES* ***Requires medication order signed by a healthcare provider.**
 21. Will you provide any of the following for school? ☐ Spacer (**recommended**) ☐ Nebulizer ☐ Peak flow ☐ Disaster meds/supplies
 22. What is your student's independence level in taking their medication?
☐ Completely independent ☐ Self-administration with adult supervision ☐ Adult gives medication
 23. Are you planning for your student to self-carry a rescue inhaler at school? ☐ NO ☐ YES*
***Final decision depends on the healthcare provider, parent, nurse approval, and consideration of the student's developmental level.**
 24. Can your student identify when they have asthma symptoms and need medication/help? ☐ NO ☐ YES
 25. In the school environment, what are your student's needs? (check all that apply):
☐ Modified recess or PE* ☐ Premedicate for exercise* ☐ Observe for side effects of medication
☐ Free access to water ☐ Avoid certain food ☐ Need special field trip planning
☐ Avoid animals at school ☐ Avoid strong odors

***Requires supporting documentation from health care provider and follow up from school nurse**

26. Is your student involved in after school sports/activities this school year? ☐ NO ☐ YES*,
 which? _____
***Parent/Guardian must inform the supervising staff member of the student's health condition.**
***Non-school-sponsored programs at ESD facilities will not have access to medications stored at school.**

CARE COORDINATION

27. Which healthcare provider is currently managing your student's asthma? _____
 28. Does your student have health insurance? ☐ NO ☐ YES, which one? _____
 29. Are you having any challenges getting asthma medication or connecting with a healthcare provider? ☐ NO ☐ YES, explain: _____

Parent/Guardian Signature: _____ Relationship: _____ Date: _____