

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

The purpose of this form is to get an UPDATE on your student's asthma. Please answer to the best of your ability and return this form to your school nurse.

1. Has your student had any asthma exacerbations this year? (i.e. urgent care or emergency room visits, hospitalizations, 911 calls, etc.)

☐ NO ☐ YES, explain: _____

2. Has anything changed with your student's asthma in the past year? (i.e. causes or symptoms, health care providers, new medication, etc.)

☐ NO ☐ YES, explain: _____

3. In the **past 1 year**, how many times has your student been:

NONE ONCE 2-4 >4

a. Hospitalized overnight or longer for asthma:

☐ ☐ ☐ ☐

b. Treated in an emergency room:

☐ ☐ ☐ ☐

c. Treated in a doctor's office for non-routine asthma:

☐ ☐ ☐ ☐

d. Prescribed steroids for asthma exacerbation:

☐ ☐ ☐ ☐

e. Absent from school for asthma-related symptoms:

☐ ☐ ☐ ☐

If more than "none," please explain: _____

4. CURRENT CAUSES: (check all that apply):

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

5. Have there been any changes to your student's typical asthma symptoms? ☐ NO ☐ YES, describe: _____

ASTHMA IMPACT (answer based on the past 1 year)

6. How often does your student have symptoms? Daytime: _____ Times/Week Nighttime: _____ Times/Week

7. Is your student's sleep interrupted by asthma symptoms? ☐ NO ☐ YES

8. Does your student limit or modify physical activity due to asthma? ☐ NO ☐ YES, explain: _____

ASTHMA TREATMENT & MANAGEMENT

9. 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.**

10. If your child has a rescue inhaler "as needed," how often do they use it? (i.e. Albuterol, Symbicort, Dulera)?

Daytime: _____ Per week Nighttime: _____ Per week

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

12. 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: _____

SCHOOL PLANNING *(if you receive this form at end-of year, complete with next school year in mind)*

13. Will you be providing medication to be kept at school? ☐ NO ☐ YES*

****New medication authorization form signed by a healthcare provider and parent is required each school year.***

14. Will you provide any of the following for school? ☐ Spacer (**recommended**) ☐ Nebulizer ☐ Peak Flow ☐ Disaster Meds/Supplies

15. 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.***

16. What is your student's independence level in recognizing they are having asthma symptoms?

☐ Completely Independent ☐ Needs help identifying symptoms ☐ Completely dependent on adult

17. What is your student's independence level in taking their medication?

☐ Completely Independent ☐ Self-administration with adult supervision ☐ Adult gives medication

18. 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***

19. Will your student be involved in after school sports/activities this school year? ☐ NO ☐ YES*, which? _____

****Parent must inform 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

20. Which healthcare provider is currently managing your student's asthma? _____

21. Does your student have health insurance? ☐ NO ☐ YES*, which one? _____

22. Are you having any challenges getting asthma medication or connecting with a healthcare provider? ☐ NO ☐ YES, explain: _____

23. Have there been any changes to health or any new medical updates? ☐ NO ☐ YES (For example: anaphylaxis, allergies, heart, respiratory, mental health conditions) If so, please explain: _____

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