Asthma History Form

When was your child diagnosed with asthma? ______________________________

How do you rate your child's asthma: ☐Mild ☐Moderate ☐Severe ☐Life-threatening

Date of last asthma symptoms: ______________________

What triggers your child's asthma?

☐Illness ☐Food ☐Strong odors/fumes
☐Exercise ☐Cigarette smoke ☐Animal dander or feathers
☐Change in weather (cold air) ☐Environmental allergens ☐Other: __________________________

Symptoms your child may have during an asthma episode:

☐Coughing ☐Wheezing ☐Chest tightness
☐Shortness of breath ☐Bluish color of lips/nail beds ☐Other: ___________________________

What helps your child recover from asthma symptoms:

☐Rescue inhaler ☐Nebulizer treatment ☐Rest/relaxation ☐Other: ____________________

List limitation/special needs your child may school events:

☐ Modified PE/playground/sports ☐Field Trips ☐ NO Animals in classroom ☐Other: _____________

Limitations/Accommodations:
____

List medication(s) your child will need at school: (Medication Authorization Form Required) _______________
____

List medication(s) your child takes at home: ____

Asthma Specialist: ____ **Phone:** ________________

Primary Care Physician: ____ **Phone:** ________________

Asthma Intake Form (AIF)

Student Name: ________________________ Date of Birth: ____________ Gender: M / F Grade ____

Parent Contact: ________________________________ Ph. Number: ____________________________

Is your Child's Asthma Life-Threatening?

According to RCW 28A.210.320, children with life-threatening asthma are required to have an emergency care plan and medication (if ordered) at school. Please answer the questions below and return to your child's school.

1. Does your child take daily medication for his/her asthma? ☐ Yes ☐ No
   If yes, name of medication: ____

2. Within the last year has your child:
   - Had a sudden, severe asthma attack? ☐ Yes ☐ No
   - Been seen in the emergency room for an asthma episode? ☐ Yes ☐ No
   - Been hospitalized overnight for an asthma episode? ☐ Yes ☐ No
   - Been seen by a health care provider for an asthma episode? ☐ Yes ☐ No

3. Does your child use a rescue inhaler or emergency nebulizer treatment for an asthma episode more than twice a week? ☐ Yes ☐ No
   - If yes, how many times per week? ____

4. Does your child have a history of severe allergic reactions? ☐ Yes ☐ No
   - If yes, describe: ____

☐ I have filled out the **Authorization for Medication at School** and it is signed by a **Doctor and Parent** for my child to **self-carry his/her inhaler at school.**

Parent /Guardian Signature: _______________________________________ Date: _________________

***As the Parent/Guardian you are responsible for communicating any changes in your child's health condition with the school nurse. This form will be put in your child's permanent health file and will continue year to year unless you notify the school nurse of changes regarding your child's health condition. ***