Asthma Information for School

Student Name: _____ Date of birth: _____ Date: _____

Parent/Guardian: _____ Cell: _____ Work: _____

Health Care Provider treating Asthma: _____ Phone: _____

How often does your Health Care Provider want to see your student for an asthma check-up? _____
When did your student last see the Health Care Provider for asthma? _____
Do **you think** your student's asthma may be **life-threatening**? ❑ No ❑ Yes
Does your student's **health care provider think** the asthma may be **life-threatening**? ❑ No ❑ Yes

History and Current Status

How long has your student had asthma? _____
-Missed school due to asthma? Number of days ____
-Been seen in the emergency room for asthma? Number of times _____ Date last seen _____
-Stayed overnight in the hospital? Number of times _____ Date last stayed _____
-Been treated in Health Care Providers office for asthma? Number of times _____
-How many days of work have you missed due to your student's asthma in the last year? _____ days

Triggers and Symptoms

What triggers your student's asthma? *(Check all that apply.)*

❑ Exercise ❑ Strong odors/fumes ❑ Food
❑ Respiratory infections (colds) ❑ Cigarette smoke ❑ Mold
❑ Changes in air temperature ❑ Emotions/stress ❑ Carpets
❑ Changes in seasons ❑ Animals ❑ Dust ❑

Other
Explain any triggers you have checked above _____

What are the early warning signs of an asthma episode? *(Check all that apply.)*

❑ Cough that persists ❑ Wheezing ❑ Tired, low energy
❑ Drop in peak flow ❑ Cold symptoms ❑ Other

Describe any symptoms you have checked above _____

Does your student understand asthma triggers and dependably report any signs? ❑ Yes ❑ No

Treatment

Does your student use a peak flow meter at home? ❑ Yes ❑ No
Will you be supplying a peak flow meter for use at school? ❑ Yes ❑ No
Do you have special instructions for medication based on the peak flow rate? ❑ Yes ❑ No
If yes, explain: _____
Do you have an Asthma Management Plan from your Healthcare Provider? ❑ Yes ❑ No
Do you expect asthma to affect your student at school? ❑ Yes ❑ No

Please list ALL medications including herbal remedies that your student takes at home and at school: ❑ None

Medication	Dose or amount	How often	When to use

Special instructions about medications at school: _____

Student may self-carry inhaler with them at school ❑ Yes ❑ No
Student may self-administer inhaler at school ❑ Yes ❑ No

Please check all your concerns related to your student's asthma that we need to consider at school:

❑ None ❑ Animal/pets in classroom ❑ Access to water
❑ Recess/PE/sports ❑ Field trips ❑ Transportation to/from school
❑ Specific foods ❑ Other _____ ❑ Observation of med side effects

RN signature _____Date_____

Parent/Guardian signature: _____ Date: _____

RN signature _____Date_____