Parent Form - Asthma History

Student’s Name: ____________________________________         Date of Birth _______________
School ___________________________    Grade/Teacher _______________________

Please provide the following information:

1. Name of medical provider treating your child’s asthma: _________________________________________

2. Does your child have health concerns other than asthma? _______________________________________

3. When was this student’s asthma first diagnosed? ______________________________________________

4. How many times has student been seen in the emergency room for asthma in the past year? ________

5. How many times has this student been hospitalized for asthma in the past year? _________________

6. Has this student ever been admitted to an intensive care unit for asthma? ______ When? _____________

7. How would you rate the severity of this student’s asthma? (please circle number below)
   (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

8. How many days would you estimate this student missed last year because of asthma? ______________

9. What triggers this student’s asthma? (Check all that apply)
   □ Exercise                          □ Respiratory infection       □ Carpets
   □ Cigarette smoke                  □ Stress                         □ Carpets
   □ Wood smoke                       □ Chalk dust                    □ Temperature changes
   □ Pollen                           □ Indoor dust                   □ Other: ______________________
   □ Strong odors or fumes            □ Outdoor dust                  □ Other: ______________________
   □ Animals (specify): _______________  □ Foods (specify): _______________

10. What does this student do at home to relieve asthma symptoms? (Check all that apply)
    □ Breathing exercises             □ Takes medications (see below)
    □ Drinks liquids                  □ Uses herbal remedies (see below)
    □ Rest/relaxation                 □ Other: _______________________
11. Control of School Environment: List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

12. What medication does this student take for asthma (every day and as needed):

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Amount</th>
<th>Delivery Method (nebulizer, inhaler, etc.)</th>
<th>How Often</th>
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10. What herbal remedies, if any, does this student take for asthma? _______________________________

11. Does this student use any of the following aids for managing asthma?

- Holding chamber/Spacer
- Holding chamber/Spacer with mask
- Peak flow meter (personal best________)
- Other: __________________

12. Please check special needs related to your child’s asthma:

- Physical education class
- Avoidance of certain foods
- Transportation
- Observation of side effects
- Recess
- Field trips
- Animals in classroom
- Access to water
- Other: __________________

13. If you checked any of the above, please describe needs: _______________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Parent/Guardian Signature: ______________________________________ Date: _________________

Reviewed by school nurse: ______________________________________ Date: _________________