# Asthma Information for School

Student Name: ___________________________________ Date of birth ___________Date ___________

Parent/Guardian: ____________________________Phone _______________Cell/work_______________

Health Care Provider treating Asthma: ____________________________Phone_____________________

How often does your Health Care Provider want to see your student for 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

**<u>History and Current Status</u>**

How long has your student had asthma? __________________________________________________
How many times in the past year has your student:
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

**<u>Triggers and Symptoms</u>**

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

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

Explain any triggers you have checked:_____________________________________________________
_____________________________________________________________________________________

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

❑ Cough that persists
❑ Drop in Peak Flow
❑ Wheezing
❑ Cold symptoms
❑ Tired, low energy
❑ Other

Describe any symptoms checked above: ____________________________________________________
_____________________________________________________________________________________

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

**<u>Treatment</u>**

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 the medication your student takes at home and at school: ❑ None

| Medication | Dose or amount | How often | When to use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Special Instructions about medications at school: ________________________________________________
_____________________________________________________________________________________

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

❑ None
❑ Recess/gym class/sports
❑ Specific Foods
❑ Animal/Pets
❑ Field Trips
❑ Other: ______________________________

Parent/Guardian Signature: ________________________________________ Date: __________________


RN signature ________________________ date _________