ASTHMA INFORMATION FOR SCHOOL

PLEASE RETURN TO SCHOOL NURSE

Student Name: _____ Grade: _____ Today's date: _____

Parent/Guardian: _____ Phone: _____

Physician treating asthma: _____ Phone: _____

1. When was your child diagnosed with asthma? _____
2. Has your child had pneumonia or bronchitis? _____ How often?_____
3. When was the last time your child:
   was treated in the emergency room for asthma? _____
   was admitted to the hospital for asthma? _____
4. How often does your child miss school because of breathing problems? _____
5. What triggers your child's asthma? (Check all that apply)

☐ Exercise	☐ Strong odors	☐ Molds
☐ Respiratory infections, colds	☐ Cigarette smoke	☐ Animals
☐ Changes in weather	☐ Pollens	☐ Menstrual cycle
☐ Cold air	☐ Foods	☐ Other: _____
☐ Laughing or crying hard	☐ Dust	

6. What are your child's asthma symptoms? (Check all that apply)

☐ Cough	☐ Tickle in throat	☐ Anxiety
☐ Wheezing	☐ Chest tightness	☐ Headache
☐ Shortness of breath	☐ Fatigue	☐ Other:_____

7. How many times in the last month has your child had symptoms during the day? _____
8. How many times in the last month has your child had symptoms during the night? _____
9. When does your child have breathing problems? _____
10. How does asthma limit your child's exercise or activity? _____
11. How do you treat your child's asthma? _____
12. Please list **ALL** the medications you child takes at home and at school:

Name of medication:	Amount/dose:	How often used:

13. Does your child have any allergies? ☐ No ☐ Yes; please list: _____
14. Does your child use a peak flow meter? ☐ No ☐ Yes Spacer? ☐ No ☐ Yes
15. Are there any concerns related to your child's asthma that we need to consider at school?