ASTHMA HISTORY

Date _____

Student's Name _____DOB _____Grade _____

1. Has a healthcare provider diagnosed your child with asthma? No____ Yes ____ At what age? _____
   If yes, name of physician treating child's asthma: _____
   Physician's phone # _____
2. Does your child have a Section 504 Plan for this health condition? ___ No ____Yes

3. Has your child's asthma attacks/flares resulted in an emergency room visit or hospitalization? ___No ___Yes
   If so, when?_____, Explain _____
   _____
4. How often does your child have an asthma attack/flare? _____
5. When was the last attack/flare? _____

6. Has your child been prescribed medication for the treatment of asthma? ____No ____ Yes
   List all medications prescribed for your child:

Medication Name	Dosage	Frequency	Will this medication be given at school Yes/No

7. Will medication be provided for us to administer at school ____ No ____ Yes
   - If yes, list medication _____

8. What are the sign and symptoms of your child's asthma (coughing; wheezing; shortness of breath; chest tightness, pain, or pressure, other)? _____
   _____
9. What are the early signs of your child's asthma? _____

10. What commonly triggers your child's asthma or makes it worse? (Tobacco smoke, dust mites, pets, mold, outdoor air pollution, other) _____
    _____

11. How would you describe your child's level of independence managing his/her asthma at school including using an inhaler? Level of Independence: ☐Independent ☐ Needs Supervision ☐ Needs Full Assistance
    Comments: _____

Parent/Guardian Name: _____ Date: _____
Parent/Guardian Signature: _____

Reviewed by RN: _____ Date: _____