

## Asthma History Form

Student name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_

Asthma Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Age of child when first diagnosed with asthma? \_\_\_\_\_

Has your child had 2 or more ER visits or hospitalizations in the past year?

- ☐ No  
☐ Yes. Most recent visit/admission \_\_\_\_/\_\_\_\_/\_\_\_\_

How often does your child's asthma interfere with her/his daily routine?

- ☐ None  
☐ Some limitations  
☐ Extremely limited

How often does your child use short-acting inhalers? (Albuterol or Xopenex, Pro-air)

- ☐ Less than 2 days a week  
☐ More than 2 days a week  
☐ Several times a day

How many times has your child had an asthma related event requiring oral steroids (prednisone)?

- ☐ 0 – 1 time year  
☐ More than 2 times a year  
☐ Not required medication since \_\_\_\_/\_\_\_\_/\_\_\_\_

Does your child receive nebulizer treatments?

- ☐ No  
☐ Yes

What triggers your child's asthma?

- ☐ Illness/Fatigue  
☐ Food  
☐ Weather  
☐ Medications  
☐ Exercise  
☐ Emotions  
☐ Cigarette smoke  
☐ Chemical odors  
☐ Other: \_\_\_\_\_

Can your child avoid triggers and identify symptoms of an asthma attack?

- ☐ No  
☐ Yes

What special accommodations apply to your child's asthma?

- ☐ Peak flow meter  
☐ PE Class  
☐ Animals in classroom  
☐ Recess  
☐ Avoidance of certain foods  
☐ Transportation to/from school  
☐ Observation of side effects from medications

Does your child take any other medication for her/his asthma? \_\_\_\_\_

**If medication is needed at school**, please have your child's Health Care Provider complete the Authorization for Administration of Medication form. Bring the completed form and medications to school before your child begins attending.

The information you provided may be used to create an Individual Health Plan for your child's care and may be shared with school staff on a need-to-know basis.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_