ASTHMA HISTORY UPDATE

Student's Name: _____ Date of Birth: _____

School: _____ Grade/Teacher _____

Parent/guardian name(s): _____

Home phone: _____ Work phone: _____ Cell/pager: _____

Alternate contact: _____ Phone: _____

Primary Health Care Provider: _____ Phone: _____

How many times has this student been seen in the emergency room for asthma in the past year?: __

How would you rate the severity of this student's asthma?
(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

How many days would you estimate this student missed last year because of asthma?: _____

Has your child developed any new triggers for his/her asthma in the past year? __yes __no If yes, describe: _____

What medications does this student take for asthma (both every day and as needed PRN:

Medication Name	Amount	Delivery Method (inhaler, Nebulizer, oral, etc.)	How Often?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What herbal remedies, if any, does this student take for asthma?: _____
_____

Does this student use any of the following aids for managing asthma?:
☐ peak flow meter (personal best, if known: _____)
☐ holding chamber ☐ spacer ☐ holding chamber with mask
☐ other (specify): _____

Please check special needs related to your child's asthma:

☐ physical education class ☐ recess ☐ animals in classroom
☐ avoidance of certain foods ☐ field trips ☐ access to water
☐ transportation to and from school ☐ observation of side effects from medications
☐ other

If you checked any of the above boxes, please describe needs:

_____

_____

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

3/04