Asthma Information Form

Student's Name ___________________________ Birthdate ________________
School ___________________________ Grade _______ Class (home) room _______

The following information is helpful to the nurse and school staff in determining any special needs for your child. If you desire a conference with the school nurse, please call for an appointment. Thank you for your assistance.

School Nurse ___________________________ Phone ______________________

Please indicate which best describes your child’s asthma:

☐ Asthma is no longer a health concern for my child.

☐ Asthma is a health concern for my child but is stable and does not require medication at school.

☐ Asthma is a health concern and requires medication at school. A School Asthma Plan will be required before student is able to attend school.

1. How long has your child had asthma? ____________

2. Medications taken at home: ____________________________

3. Medications taken during school (as needed medication): ____________________________

4. Check a box below that most accurately describes the current severity of your child's asthma.

<table>
<thead>
<tr>
<th>Severity of Asthma</th>
<th>Symptoms</th>
<th>Nighttime Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild intermittent</td>
<td>Two or fewer times a week; no symptoms between episodes; brief episodes from a few hours to a few days and vary in intensity.</td>
<td>Two or fewer times a month</td>
</tr>
<tr>
<td>Mild persistent</td>
<td>Symptoms more than twice a week but less than once a day. Episodes may affect activity.</td>
<td>More than twice a month</td>
</tr>
<tr>
<td>Moderate persistent</td>
<td>Daily symptoms; daily use of short-acting inhalers. Episodes affect activity and occur at least twice a week and may last days</td>
<td>More than once a week</td>
</tr>
<tr>
<td>Severe persistent</td>
<td>Continual symptoms; limited physical activity; frequent episodes</td>
<td>Frequent</td>
</tr>
</tbody>
</table>

Please indicate what triggers your child's asthma:

☐ Respiratory infection
☐ Emotions / stress
☐ Chemical odors
☐ Foods
☐ Weather changes

☐ Exercise
☐ Cigarette smoke
☐ Medication
☐ Allergies (list) ________________

☐ Other (list) ________________

Please indicate your child's early warning signs:

☐ Cough
☐ Cold symptoms
☐ Drop in peak flow
☐ Wheezing
☐ Decreased exercise

☐ Other (list) ________________

Please check all special considerations related to your child's asthma that he/she will need while at school:

☐ None
☐ Avoiding strong smelling chemicals or irritants (chalk dust, sawdust, paint)
☐ Modified recess or gym class *Note from physician required

☐ Special considerations while on field trips
☐ Special transportation to and from school* "Note from physician recommended"

☐ Avoiding animals/pets

☐ Other ________________

Parent/Guardian Signature: ___________________________ Date: ____________