ASTHMA INFORMATION FOR SCHOOL

Student Name: _____________________________  Grade: _______   Today’s date: _______________
Parent/Guardian: __________________________________________ Phone: ___________________
Physician treating asthma: ____________________________________  Phone: ___________________

1. When was your student diagnosed with asthma? __________________________________________

2. Has your student had pneumonia or bronchitis? _________  How often?______________________

3. When was the last time your student:
   was treated in the emergency room for asthma? _____________________________________
   was admitted to the hospital for asthma? ________________________________________

4. How often does your student miss school because of breathing problems?____________________

5. What triggers your student’s asthma?  (Check all that apply)
   [ ] Exercise
   [ ] Respiratory infections, colds
   [ ] Changes in weather
   [ ] Cold air
   [ ] Strong odors
   [ ] Cigarette smoke
   [ ] Pollens
   [ ] Foods
   [ ] Molds
   [ ] Animals
   [ ] Menstrual cycle
   [ ] Other:
   [ ] Laughing or crying hard
   [ ] Dust

6. What are your student’s asthma symptoms?  (Check all that apply)
   [ ] Cough
   [ ] Wheezing
   [ ] Shortness of breath
   [ ] Tickle in throat
   [ ] Chest tightness
   [ ] Fatigue
   [ ] Anxiety
   [ ] Headache
   [ ] Other:

7. How many times in the last month has your student had symptoms during the day?_________

8. How many times in the last month has your student had symptoms during the night? _______

9. When does your student have breathing problems? _________________________________

10. How does asthma limit your student’s exercise or activity? __________________________

11. How do you treat your student’s asthma? ____________________________________________

12. Please list ALL the medications you student takes at home and at school:

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<thead>
<tr>
<th>Name of medication:</th>
<th>Amount/dose:</th>
<th>How often used:</th>
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13. Does your student have any allergies?  [ ] No  [ ] Yes; please list: ___________________

14. Does your student use a peak flow meter?  [ ] No  [ ] Yes  Spacer?  [ ] No  [ ] Yes

15. Are there any concerns related to your student’s asthma that we need to consider at school?
___________________________________________________________________________________
___________________________________________________________________________________

Parent Signature:______________________________________ Date: ________________________