HIGHLAND SCHOOL DISTRICT 203

ASTHMA HISTORY FORM

Student's Name: _____ Date of Birth: _____

History Taken by: _____ Date: _____

Parent/Guardian Name: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Alternate Contact: _____ Phone: (_____) _____

Primary Health Care Provider: _____

Office Phone: (_____) _____ Office Fax: (_____) _____

Address: _____

When was this student's asthma first diagnosed? _____

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

How many times has this student been hospitalized for asthma in the past year? _____

Has this student ever been admitted to an intensive care unit for asthma? _____

When? _____

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? _____

What triggers this student's asthma?

☐ exercise ☐ respiratory infection ☐ strong odors or fumes ☐ stress
☐ cigarette smoke ☐ wood smoke ☐ pollen
☐ animals (specify): _____
☐ foods (specify): _____
☐ carpets ☐ indoor dust ☐ outdoor dust
☐ chalk dust ☐ temperature changes ☐ molds
☐ other: _____

What does this student do at home to relieve asthma symptoms (check all that apply)?

☐ breathing exercises ☐ rest/relaxation ☐ drink liquids
☐ takes medications (see below) ☐ uses herbal remedies (see below)
☐ other (please describe): _____

HIGHLAND SCHOOL DISTRICT 203

ASTHMA HISTORY FORM, cont.

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

Medication Name	Amount	Delivery Method (nebulizer, inhaler, 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 w/mask
☐ other: _____

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

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

_____

_____

Has this student had asthma education? ☐ yes ☐ no
Would you like information about asthma education for: ☐ student ☐ self

Parent/Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

By signing you are also giving permission for information in this form to be shared with school staff on a "need to know" basis.