ASTHMA INFORMATION FOR SCHOOL

PLEASE RETURN TO SCHOOL NURSE

Date _____ School _____

Student Name: _____ Grade/Teacher: _____

Parent/Guardian: _____ Phone: _____

Physician treating Asthma: _____ Phone: _____

The following will assist the school nurse and 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.

1. How long has your child had asthma? _____
2. Do you expect asthma to impact school? ☐ yes ☐ no (If no, skip to #9)
3. How many times in the past year has your child:
   a. Missed school due to asthma? _____
   b. Received treatment in the emergency room for asthma? _____
      Date of last emergency room visit _____
   c. Been hospitalized overnight due to asthma? _____
      Date of last hospital stay _____
   d. Been treated in the doctor's office for asthma? _____
      Date of last doctor's appointment _____
      Date of last pulmonary function test _____

   How many days of work have you missed due to your child's asthma? _____

4. What triggers your child's asthma? check all that apply)

Exercise ☐	Strong odors or fumes ☐	Dust includin chalk dust
Respiratory Infections ☐	Cigarette smoke ☐	Molds ☐
Change in temperature ☐	Emotions/Stress ☐	C
Change in season ☐	Food ☐	Animals ☐
Pollens ☐	Other:	

   Explain any specific triggers above: _____

5. What are the early warning signs of an asthma episode eck all that apply)

Cough ☐	Cold Symptoms ☐	Drop in peak flow ☐
Wheezing ☐	Decreased Energy ☐	Other (specify) ☐

   Describe any symptoms above: _____

6. Does your child understand asthma triggers, and reliably report any difficulty?
☐ Yes ☐ No Comments: _____

_____

7. Does your child use a peak flow meter at home? ☐ Yes ☐ No
Will you be supplying a peak flow meter at school? ☐ Yes ☐ No
Do you have special instructions for medication based on the peak flow rate?
☐ Yes ☐ No If yes, instructions: _____

_____
(Use the attached ASTHMA MANAGEMENT PLAN as a guide if necessary).

8. Please list ALL the medication your child takes at home and at school:

Name of Medication	Amount/How often	When to use
1.		
2.		
3.		
4.		
5.		
6.		

Special Instructions about medications at school: _____

_____

_____

9. Please check all your concerns related to your child's asthma that we need to consider at school (contact nurse if needed) ☐ None
Recess/gym class/sports _____
Specific Foods _____
Field Trips _____
Animal/Pets _____
Other: _____

10. What other concerns/comments do you have about your child's health while attending school.

Parent Signature: _____ Date: _____