Asthma History

Complete only if student has asthma or history of asthma.

STUDENT_____ SCHOOL_____ GRADE _____

Dear Parent/Guardian:
Please provide your child's asthma information by completing this form and returning it to the school nurse.

1. Asthma continues to be a health concern for this student? _____Yes ____ No **If no, skip to box below.**
2. How long has this student had asthma? _____
3. What are the student's asthma triggers? _____
4. Has this student been hospitalized with asthma related problems in the last 3 years? ____Yes _____No
5. Has this student required urgent or emergency care due to asthma in the last 3 years? _____Yes ____No
6. Has this student been instructed to take daily medications to control asthma? _____ Yes _____No
   If so, what is the medication? _____
7. Has this student used asthma medications in the last year? _____Yes _____No
8. Will this student be carrying his/her inhaler at school? ____ Yes _____No **If yes, a Medication Self-Administration form must be completed and signed by the parent and healthcare provider.**
9. About how often does this student experience asthma symptoms? ____ 2 or more times per week
   ____ 2 or more times per month
   ____ 2 or more times per year
10. About how many days of school did this child miss last year due to asthma?_____
11. Physician my child sees for asthma: _____

- If you answered Yes to any question 3-7, **the school must have a current Asthma Action Plan on file**. If your physician has already developed an asthma plan, please provide a copy to the school nurse. If not, obtain a form from the school nurse.
- If your child will be carrying his/her inhaler at school, **the school must have a current Asthma Medication Self-Administration form on file.**
- Return all forms to the school nurse after your child's physician has completed it.
- School Board policy prohibits students from carrying unauthorized medication at school.

*****If your child no longer has a problem with asthma, carefully read the statement below. Initial the box if you agree with the statement, sign below and return this form to the school nurse.** It is not necessary to complete an Asthma Action Plan.

☐ My child does not require daily medications to control asthma and has not used asthma medications in more than one year. My child has not required urgent or emergency care for asthma-related problems and has not been hospitalized for asthma-related problems in more than 3 years. Please change medical record to indicate my child has "History of Asthma."

My signature below verifies that the information I have provided on this form to be accurate:

Student's Parent/Guardian_____ Date _____

RN Review: _____ SIS:_____
☐Notifications: teacher bus driver office
☐ Notes on reverse side