Asthma History

STUDENT INFORMATION

Student Name: ______________________________ Date: ____________________

Age __________ Grade _________ Room: __________ Teacher: ______________________

Parent/Guardian Name: ______________________________

______________________ ______________________ ______________________
Home Phone Cell Phone Work Phone

Parent/Guardian Name: ______________________________

______________________ ______________________ ______________________
Home Phone Cell Phone Work Phone

Emergency Contact Name: ______________________________ Phone: ______________

Physician (Seen for Asthma): ______________________________ Phone: ______________

ASTHMA HISTORY

Age of Asthma diagnosis: __________

Is asthma is well controlled? ☐ Yes ☐ No*

How often is rescue inhaler used (daily, weekly, monthly)? ______________________________

Hospitalization/s associated with asthma? ☐ Yes* ☐ No

*Provide additional information: ____

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DAILY MEDICATION MANAGEMENT

Is daily medication taken for asthma? ☐ Yes ☐ No If yes, please list below:

Name of Medication	Dose/Amount	When used:

ASTHMA TRIGGERS

Please identify triggers affecting your child:

☐ Colds/Respiratory Infections ☐ Weather ☐ Dust ☐ Pollens ☐ Smoke ☐ Strong Odors ☐ Air Pollution

☐ Exercise* ☐ Animals ☐ Carpets ☐ Mold ☐ Food ______________ ☐ Other ______________

*If asthma is triggered by exercise, please indicate asthma protocol to be followed at school:

☐ Albuterol or ____________________inhaler, _____ puffs ______ minutes before exercise.

☐ Activity restrictions ____________________ ☐ Other ____________________

PEAK FLOW METER

Does student use a Peak Flow Meter? ☐ Yes ☐ No

If yes, what is Peak Flow Personal Best __________?