# "Insert Name of School"

## OFFICE OF THE SCHOOL NURSE

### REQUEST FOR ASTHMA INFORMATION

Name: _____Date of Birth: _____Date:_____

Sponsor: _____ Teacher/Grade: _____

How long has your child had asthma? _____

Describe last asthma attach (what happened, how long it lasted, how it was treated).

_____

_____

How often does child have an attack requiring an emergency visit to the doctor or hospital?

[ ] weekly [ ] monthly [ ] yearly [ ] never

What usually triggers your child's asthma? (check all that apply)

[ ] illness [ ] exercise [ ] emotions [ ] foods

[ ] smoke/odors [ ] weather [ ] medications [ ] allergens

Has your child ever had allergy testing? ◉ No ○ Yes Allergies:

(list): _____

Is your child exposed to second hand smoke: ◉ No ○ Yes

Do you use a Peak Flow Meter at home? ◉ No ○ Yes Best volume results: _____

*List all asthma medications taken. Include as needed inhalers & steroids:*

_____

_____

Other medications taken:

_____

What is the severity of your child's asthma? [ ] mild intermittent [ ] mild persistent

[ ] moderate persistent [ ] severe persistent

Have you or your child every attended an asthma class: ◉ No ○ Yes

Do you have an asthma management plan? ◉ No ○ Yes *Please attach a copy*.

If there is other information you would like to provide, or if you have questions, please write on the reverse side of this form. Thanks you for this valuable information.

_____

Parent Signature and Date