BRUSSELS AMERICAN SCHOOL
Office of the School Nurse

REQUEST FOR ASTHMA INFORMATION

Student's Name _____ Date Of Birth _____Date_____
Sponsor/Parent_____Teacher/Grade_____

How long has your child had asthma?
_____

Describe *last* asthma attack (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 ever attended an asthma class?
_____ Yes _____ No

Do you have an asthma management plan?
_____ Yes _____ No
If yes, please attach a copy.

_____
Parent signature and date

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

Vicky Westland RN
Brussels American School Nurse