**ASTHMA HISTORY UPDATE**

Student’s Name Date of Birth

Grade/Teacher

Parent/Guardian Name(s)

Phone Work Phone Cell

Email

Alternate Contact Phone

Healthcare Provider Treating Asthma Phone

Has your primary health care provider, provided you with an asthma management plan?

How many times has this student been to the emergency room for asthma in the past year?

How do you rate the severity of this student’s asthma, where 1 is not severe and 10 is severe?

How many days would you estimate this student missed last school year because of asthma?

List usual asthma triggers:

Has this student developed any new asthma triggers in the past year?

If yes, please list

**Please list the medications taken for asthma: (include daily, as needed and herbal)**

Medication Name Delivery Method Amount How Often?

 (oral, inhaler, nebulizer, spacer, etc.)

Does your child need help administering their medication? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

**Please describe any special requirements your child has related to asthma**

Physical education class:

Animals in the classroom:

Field Trips:

Recess:

Avoidance of certain food:

Other:

Parent signature and date Nurse review and date: