

## Highland Local Schools Asthma History Form

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

When was this student's asthma first diagnosed? \_\_\_\_\_

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

How many times has this student been hospitalized for asthma in the past year? \_\_\_\_\_

Has this student ever been admitted to an intensive care unit for asthma? \_\_\_\_\_ When? \_\_\_\_\_

How would you rate the severity of this student's asthma?

(not severe)    1        2        3        4        5        6        7        8        9        10        (severe)

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

What triggers this student's asthma?

\_\_\_\_ Exercise                      \_\_\_\_ Strong odors or fumes                      \_\_\_\_ Chalk dust                      \_\_\_\_ Carpets

\_\_\_\_ Cigarette smoke                      \_\_\_\_ Respiratory infection                      \_\_\_\_ Indoor dust                      \_\_\_\_ Molds

\_\_\_\_ Wood smoke                      \_\_\_\_ Stress                      \_\_\_\_ Outdoor dust                      \_\_\_\_ Temperature changes

\_\_\_\_ Pollen

\_\_\_\_ Animals (specify): \_\_\_\_\_

\_\_\_\_ Foods (specify): \_\_\_\_\_

\_\_\_\_ Other: \_\_\_\_\_

What does this student do at home to relieve asthma symptoms? (Check all that apply)

\_\_\_\_ Breathing exercises                      \_\_\_\_ Takes medications (see below)

\_\_\_\_ Drinks liquids                      \_\_\_\_ Uses herbal remedies (see below)

\_\_\_\_ Rest/relaxation                      \_\_\_\_ Other: \_\_\_\_\_

### **Control of School Environment**

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**What medication does this student take for asthma (every day and as needed):**

Name	Amount	Delivery Method (nebulizer, inhaler, etc.)	How Often
------	--------	---	-----------

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

What herbal remedies, if any, does this student take for asthma? \_\_\_\_\_

Does this student use any of the following aids for managing asthma?

- |  |   |
|--|---|
| <input type="checkbox"/> Holding chamber           | <input type="checkbox"/> Peak flow meter (personal best if known _____) |
| <input type="checkbox"/> Spacer                    | <input type="checkbox"/> Other: _____                                   |
| <input type="checkbox"/> Holding chamber with mask |   |

Please check special needs related to your child's asthma:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Physical education class          | <input type="checkbox"/> Observation of side effects | <input type="checkbox"/> Animals in classroom |
| <input type="checkbox"/> Avoidance of certain foods        | <input type="checkbox"/> Recess                      | <input type="checkbox"/> Access to water      |
| <input type="checkbox"/> Transportation to and from school | <input type="checkbox"/> Field trips                 | <input type="checkbox"/> Other: _____         |

If you checked any of the above, please describe needs:

\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_