**EDMONDS SCHOOL DISTRICT NO. 15**
**Educational Health Services**
**ASTHMA INFORMATION FORM**

Student: _____ Grade: _____ DOB: _____ School: _____

**The following information is helpful to the nurse and school staff in determining any special needs for your child. Please answer the questions to the best of your ability and return this form to your school nurse. Thank you for your assistance.**

1. How long has your student had asthma? _____
2. How many days would you estimate s/he missed school ***last year*** due to asthma? _____
3. How many times in the ***PAST YEAR*** has your child been:
   - Hospitalized overnight or longer for asthma (check one): none _____one _____ 2-4 _____more than four_____
   - Treated in an emergency room: none _____one _____ 2 _____ 3 _____ 4 _____ more than four_____
   - Treated in a doctor's office for non-routine asthma: none _____one _____ 2 _____ 3 _____ 4 _____ > 4 ____
4. Does your student have a ***past history of:***
   - Sudden severe asthma attacks ☐ No ☐ Yes: Explain _____
   - Prior intubation/mechanical ventilation for asthma ☐ No ☐ Yes: when _____
   - Prior admission to an ICU for asthma ☐ No ☐ Yes: when _____
5. **Asthma Triggers**: (Check each that applies to student)

   ☐ Exercise ☐ Stress ☐ Respiratory Infections ☐ Emotions

   ☐ Food ☐ Cigarette smoke ☐ Strong odors or fumes ☐ Change in Temperature

   ☐ Changes in weather ☐ Chalk Dust ☐ Animals ☐ Carpets

   ☐ Allergies: check which allergies: ☐ Foods ☐ Pollen ☐ Dust Mites ☐ Grasses ☐ Trees ☐ Other: _____

   Allergy medication: On: daily ☐ as needed ☐ medication for allergies? ☐ No ☐ Yes: what? _____
6. **Control of School Environment:** (Check each that applies to student)

   ☐ Avoid strong odors (chalk dust, paint, irritants, etc) ☐ Modified recess or PE *

   ☐ Avoiding certain foods ☐ Pre-medication for exercise

   ☐ Field trip considerations ☐ Special transportation to/from school *

   ☐ Avoiding animals/pets in classroom/school ☐ Does student take bus to school? ☐ No ☐ Yes: _____

   ☐ Observation of side effects of medication ☐ Access to water

   * Note from HCP (Health Care Provider) required ☐ Involved in after school sports/activities? _____
7. **Peak Flow Monitoring:** Does your student use a Peak Flow Monitor?: ☐ No ☐ Yes: please complete below

   Personal Best Peak Flow Number _____

   Monitoring times: _____ _____ _____

   Green zone: _____ Yellow zone: _____ Red zone: _____

   Does your student have a written Asthma Management Plan? ____ no ____ yes: If so, please provide the school a copy
8. **Treatment Plan: Please list <u>ALL</u> asthma medications**

| Medication Name | Dosage | Times/day | Indications to Give | Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Will your student carry an albuterol inhaler at school? ☐ No ☐ Yes: where? _____**
Is your student involved in after school sports or activities: ☐ No ☐ Yes: what? _____

****It is your responsibility to inform adult/coach of your student's medical condition****

Will you be providing for school: □ Peak Flow Meter □ Disaster Supplies (medications for 3 days)

Student's Health Care Provider: _____ Phone: _____

Seen a specialist?: □ No □ Yes: _____ Had immunotherapy? □ No □ Yes: _____

Allergy testing?: □ No □ Yes: when/where: _____

9. **Early Warning Signs:** for *your* student

| | | | |
|---|---|---|---|
| □ Cough | □ Cold symptoms | □ Drop in peak flow | □ Wheezing |
| □ Decreased exercise | □ Stuffy/runny nose | □ Itchy/watery eyes | □ Itchy throat/chin |
| □ Stomachache | □ Dark circles under eyes | □ Funny feeling in chest | □ Behavioral changes |
| □ Irritability | □ Decreased appetite | □ Fatigue | □ Headache |
| □ Persistent coughing | □ Other: _____ | | |

10. **Acute Asthma Signs and Symptoms:** for *your* student

| | | | |
|---|---|---|---|
| □ Anxious or scared | □ Vomiting from hard coughing | □ Short of breath | □ Rapid labored breathing |
| □ Incessant coughing | □ Wheezing while breathing in/out | □ Unable to speak in full sentences | □ Nasal Flaring |
| □ Sweaty/clammy skin | □ Pull in neck/chest muscles | □ Tightness in chest | □ Shoulders hunched over |
| □ Spitting up mucus | □ Fatigue | □ Increased respiratory rate: _____ | |
| □ Decreased peak flow _____ | | □ Skin color pale, blue-grey around lips/under eyes | |

10. **Asthma Severity Assessment**: **Please check appropriate box that describes your student's symptoms:**

| | Severity of Asthma | Symptoms | Nighttime Symptoms |
|---|---|---|---|
| □ | Mild intermittent | Two or fewer times a week; no symptoms between episodes; brief episodes from a few hours to a few days and vary in intensity. | Two or fewer times a month |
| □ | Mild persistent | Symptoms more than twice a week but less than once a day. Episodes may affect activity. | More than twice a month |
| □ | Moderate persistent | Daily symptoms; daily use of short-acting inhalers. Episodes affect activity and occur at least twice a week and may last days | More than once a week |
| □ | Severe persistent | Continual symptoms; limited physical activity; frequent episodes | Frequent |

**How often does your student use the Albuterol inhaler during the day? _____/week At night? _____/week**

**When was the last time the Albuterol inhaler was used**? _____Why? _____

**How many canisters of Albuterol are typically used in one month period? _____**

**Has your student been on oral steroids before** ☐ No ☐ Yes: Date (s): _____

11. **Emergency Plan:** What does this student do at home to relieve asthma symptoms (check all that apply)

□ Breathing exercises □ Rest/relax □ Drink liquids □ Medications □ Herbal remedies □ Other: _____

12. **Student Health Education:** Please review topics with your student and write in date of review:

| Topics …… | Taught | Topics …… | Taught |
|---|---|---|---|
| Triggers | | Medications: purpose, how to use, dose, frequency | |
| Signs/Symptoms of attack | | effectiveness, side effects | |
| Come to health center if symptoms | | When to call home: symptoms (Sx) vs. Sx persist | |
| Always come with another person | | Other: | |

**13. Does your student have health insurance?** □ Yes: Name: _____ □ No

_____ _____ _____ _____

**Parent/Guardian Signature** **Relationship** **Date** **E-mail Address**

_____ _____

**Student Signature** **Date**