

# Asthma History

St Joseph School, Brookfield, CT

## To Be Completed by a Parent/Guardian

You have noted on school records that your child has asthma. This form will help to formulate a plan of care specific to your child. Please complete and return it prior to the start of school. If you have any questions or need to speak to the nurse please call the office or drop in to see the nurse.

Student \_\_\_\_\_ DOB \_\_\_\_\_  
Grade \_\_\_\_\_ Allergies: \_\_\_\_\_  
Asthma condition: (circle condition) Mild Moderate Severe Exercise Induced

**Asthma symptoms are triggered** by: (circle all that apply) exercise, illness, allergic reaction, food, pollen, cold air, smoke, air pollution, dust, mold, emotional stress, odors \_\_\_\_\_  
other \_\_\_\_\_

Usual asthma symptoms :(circle all that apply) cough, shortness of breath, chest tightness, wheezing  
Other \_\_\_\_\_

How often do the asthma attacks occur? \_\_\_\_\_

Has hospitalization for asthma been needed in the past 2 years? No\_\_\_ Yes\_\_\_. If yes, when \_\_\_\_\_

What hospital do you prefer? \_\_\_\_\_

Has your child been taught how to use his inhaler? No\_\_\_ Yes\_\_.

Is a peak flow meter used? No\_\_\_ Yes\_\_\_. Best flow rate is \_\_\_\_\_.

Does your child use an air chamber with his inhaler? No\_\_\_ Yes\_\_.

Who is currently treating your child's asthma \_\_\_\_\_

Doctor's phone number \_\_\_\_\_

Medications

Are medications needed to control the asthma? No\_\_\_ Yes\_\_\_ (list them below)

1. \_\_\_\_\_ dose \_\_\_\_\_ how often \_\_\_\_\_  
2. \_\_\_\_\_ dose \_\_\_\_\_ how often \_\_\_\_\_  
3. \_\_\_\_\_ dose \_\_\_\_\_ how often \_\_\_\_\_  
4. \_\_\_\_\_ dose \_\_\_\_\_ how often \_\_\_\_\_

The usual plan of care is to:

- Stop activity and help student to a sitting position
- Stay calm and reassure student
- Assist student with inhaler or escort him to the Health Office

**911 will be called if symptoms do not respond or worsen.**

You will also be called during this emergency.

\_\_\_\_\_  
Parent signature Date