

School Health Services Community Unit School District 303



ASTHMA ASSESSMENT

Date: _____

Student Name _____ Grade _____

According to your child's health record, he/she has asthma. Please provide us with more detailed information by completing the following questions. It will be useful in the event of an emergency, particularly if we have difficulty locating you. Please return this form to your child's school nurse.

1. Name and phone number of the physician treating your child's asthma:

2. Indicate which of the following usually triggers this child's asthma episodes:

exercise/overexertion	fatigue	infection	allergy
weather conditions	excitement/anxiety	irritants (aerosols, pollution)	
other (specify) _____			

3. Indicate your child's early signs of an asthma episode:

chest tightness	coughing	tickly throat	
shortness of breath	wheezing	nausea	mood changes
other (specify) _____			

4. If physical exertion induces or contributes to your child's episode of asthma, list any forms of exercise that should be completely avoided. _____

5. Indicate the weather conditions that affect your child:

extreme cold	extreme heat	high humidity	high wind
other (specify) _____			

6. Please indicate the types of allergies that affect your child:

pollens	dust	animals	foods	medications
other (specify) _____				

PLEASE COMPLETE BOTH SIDES

7. List all of the medications taken routinely. Indicate the dose, how often taken, when and under what circumstances additional doses are given. ***See note below***

<u>Medication</u>	<u>Dose</u>	<u>Time</u>
-------------------	-------------	-------------

8. Does your child suffer any side effects from these medications? If so, please list them.

9. Explain other asthma management measures that your child does to help alleviate his/her asthma symptoms (belly breath, fluids, rest).

10. Do you know what your child's baseline peak flow rate is? Yes _____ No _____ Rate _____

11. How do you want the school to treat an asthma episode if it should occur?

12. How long has your child had asthma?

13. Approximately how often does your child have an acute asthma episode?

14. How many times has your child been hospitalized overnight or longer for asthma in the last year?

15. How many times has your child been treated in the emergency room for asthma in the past year?

16. Estimate the number of days of school your child missed last year due to asthma: _____

17. If your child does NOT respond to medication or management measures, what action do you advise school personnel to take?

18. Additional comments:

Signature of Parent/Guardian

Date