ASTHMA ASSESSMENT FORM

Student's Name: _____ Date: _____

School: _____

Parent/Guardian: _____ Home Phone: _____

_____ Work Phone: _____

Physician Treating Child's Asthma: _____ Phone: _____

According to your child's health records, he/she has a diagnosis of asthma. The school nurse, health technician and school staff can provide better support for your child if we have the following information. Please answer the questions to the best of your ability. If you would like to conference with the school nurse, please call for an appointment.

Nurse's Name: _____ Phone: _____

1. When was your child diagnosed with asthma?
   _____
2. Please rate the severity of his/her asthma (circle) 0 1 2 3 4 (0 least severe-4 most severe)
3. What education have you received about asthma?
   _____
4. What education has your child received about asthma?
   _____
5. What triggers your child's asthma? (Please check any that apply.)

☐ Illness ☐ Emotions ☐ Medications ☐ Foods

☐ Weather/cold ☐ Exercise ☐ Cigarette or other smoke ☐ Chemical Odors

☐ Allergies/cold (please list) _____

☐ Other (please list) _____

If applicable, season(s) when asthma episodes are most likely to occur: _____

6. How often does your child have symptoms of his/her asthma? _____
7. What are his/her symptoms? _____
8. What does your child do at home to relieve wheezing or other symptoms of an asthma attack (please check any that apply.)

☐ Breathing exercises

☐ Rest/ relaxation

☐ Drinking liquids

Taking medication: ☐ Inhaler ☐ Nebulizer ☐ Oral medication

Other (please describe) _____

9. What medications does your child take, what dose and how often?

   Every day: _____

   Just for wheezing/attacks: _____

   Before exercise: _____

   Just certain times of the year or when ill: _____

10. Does your child use a spacer (extension tube, Inspirease kit or other device) with his/her inhaler?

    ☐ Yes ☐ No Type _____

11. What medications will your child need to take in school? (Please list name of medication, dose, and when it is to be taken.)

    _____
    _____
    _____

12. Who is responsible for remembering to take the medication at home?

    ☐ Parent ☐ Child ☐ Both

13. What, if any, side effects does your child have from his/her medication?

    _____

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

    _____

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

    _____

16. How often does your child see his/her doctor for routine asthma evaluations? _____

17. Does your child also have allergies? ☐ Yes ☐ No If yes, please describe: _____

_____

18. What reactions does your child have with above allergies? _____

    _____

19. Does your child use a peak flow meter? ☐ Yes ☐ No Personal best _____

20. Has your child attended Camp Superkids (a special camp sponsored by the American Lung Association at YMCA'S Camp Iduapi)? ☐ Yes ☐ No

21. Would you be interested in receiving information on asthma education programs? ☐ Yes ☐ No

Thank you for your time and assistance in helping us assess your child's special needs related to asthma at school.