EAST SIDE UNION HIGH SCHOOL DISTRICT

Asthma Information Sheet

Student's Name: _____ **Date:** _____

Birthdate: _____ **School:** _____ **Grade:** _____

Parent's Name(s): _____ **Home#:** _____ **Wrk.#:** _____ **Cell#:** _____

Name of Student's Doctor for Asthma: _____ **Telephone #:** _____

The following information is helpful to your child's school in determining any special needs for your child. Please answer the questions to the best of your ability.

1. **How long has your student had asthma?** _____

2. **Please rate the severity of his/her asthma. (Circle)**
   (Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. **How many days would you estimate he/she missed school last year due to asthma?** _____

4. **What triggers your student's asthma attacks? (Please check any that apply)**
   ☐ **Illness** ☐ **Emotions** ☐ **Medications** ☐ **Foods** ☐ **Weather**
   ☐ **Exercise** ☐ **Cigarette or Chemical Odors** ☐ **Other Smoke** ☐ **Fatigue**

   Allergies (please list): _____

   Other (please list): _____

5. **What does your child do at home to relieve wheezing during an asthma attack? (Please check any that apply)**
   ☐ **Breathing Exercises** ☐ **Rest/Relaxation** ☐ **Drinks Liquids**
   Takes Medication: ☐ **Inhaler** ☐ **Nebulizer** ☐ **Oral medication**
   Other (please describe _____

   _____

6. **Please list the medications your student takes for asthma (everyday and as needed).**

	Name of Medication	Dose	Frequency
In School			
At Home			

If Medications are to be given during school, a medication permission slip needs to be filled out yearly. Medications must be in the original labeled container. (When you get prescriptions filled you can ask the Pharmacist to put them into two containers so you'll have one for school and one for home use.)

7. **If your student does not respond to medication, what action do you advise school personnel t to take?** _____

8. What, if any, side effects does your student have from his/her medications? _____

_____

9. Has your student been taught how to use a spacer or other appliance with his/her inhaler?
☐ Yes ☐ No

10. How many times has your student been hospitalized overnight or longer for asthma in the past year? _____

11. How many times has your student been treated in the emergency room for asthma in the past year? _____

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

_____

13. Does your student need any special considerations related to his/her asthma while at school?
☐ Yes ☐ No

14. Do you know what your student's baseline peak flow rate is?
☐ Yes ☐ No Rate: _____

15. Do you think your student holds him/herself back from participating in all activities at school because of his/her asthma? If so, please explain: _____

_____

16. Have you ever attended an asthma education class? ☐ Yes ☐ No

17. Has your student had asthma education? ☐ Yes ☐ No

Thank you for your time and assistance in assessing your student's special needs at school.

_____ _____

(Parent Signature) Date