

Wilson Creek School District Asthma Information for School

Student Name: _____ Date of birth: _____ Date: _____

Parent/Guardian: _____ Daytime Phone #1 _____ #2 _____

Health Care Provider treating Asthma: _____ Phone _____

How often does your Health Care Provider want to see your student for asthma check-up? _____

When did your student last see the Health Care Provider for asthma? _____

Do **you think** your student's asthma may be **life-threatening**? No Yes

Does your student's **Health Care Provider think** the asthma may be **life-threatening**? No Yes

History and Current Status

How long has your student had asthma? _____

How many times in the past year has your student:

Missed school due to asthma? Number of days _____

Been seen in the emergency room for asthma? Number of times _____ date last seen _____

Stayed over night in the hospital? Number of times _____ date last stayed _____

Been treated in Health Care Providers office for asthma? Number of times _____

How many days of work have you missed due to your student's asthma in the last year? _____ days

Triggers and Symptoms

What triggers your student's asthma? (*check all that apply*)

- | | | |
|--|---|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors/fumes | <input type="checkbox"/> Food |
| <input type="checkbox"/> Respiratory infection (colds) | <input type="checkbox"/> Cigarette Smoke | <input type="checkbox"/> Mold |
| <input type="checkbox"/> Changes in air temperature | <input type="checkbox"/> Emotions/stress | <input type="checkbox"/> Carpets |
| <input type="checkbox"/> Changes in seasons | <input type="checkbox"/> Animals | <input type="checkbox"/> Dust <input type="checkbox"/> Other |

Explain any triggers you have checked: _____

What are the early warning signs of an asthma episode? (*check all that apply*)

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough that persists | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Tired, low energy |
| <input type="checkbox"/> Drop in Peak Flow | <input type="checkbox"/> Cold symptoms | <input type="checkbox"/> Other |

Describe any symptoms checked above: _____

Does your student understand asthma triggers, and dependably report any signs? Yes No

Treatment

Does your student use a peak flow meter at home? Yes No

Will you be supplying a peak flow meter for use at school? Yes No

Do you have special instructions for medication based on the peak flow rate? Yes No

If yes, explain: _____

Do you have an Asthma Management Plan from your Healthcare Provider? Yes No

Do you expect asthma to affect your student at school? Yes No

Please list ALL the medication your student takes at home and at school: None

Medication	Dose or amount	How often	When to use

Special Instructions about medications at school: _____

Please check all your concerns related to your student's asthma that we need to consider at school:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Animal/Pets |
| <input type="checkbox"/> Recess/gym class/sports | <input type="checkbox"/> Field Trips |
| <input type="checkbox"/> Specific Foods | <input type="checkbox"/> Other: _____ |

Parent/Guardian Signature: _____ Date: _____