

ASTHMA INFORMATION SHEET

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

Treating Physician for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

• When was the student diagnosed with asthma? _____

• How often do asthma episodes occur? _____

• List recent hospitalizations and/or visits to Urgent Care for asthma or respiratory episodes _____

• Do any other family members have asthma? If yes, who?

• Is a Peak Flow Meter used? No Yes. How often? _____ Best flow rate: _____

• Check any conditions that **TRIGGER** an asthma episode:

<input type="checkbox"/> Respiratory infection	<input type="checkbox"/> Exercise (describe) _____
<input type="checkbox"/> Changes in temperature	<input type="checkbox"/> Odors (describe) _____
<input type="checkbox"/> Emotional stress	<input type="checkbox"/> Allergic reactions to: _____
<input type="checkbox"/> Smoking	<input type="checkbox"/> Food: _____
<input type="checkbox"/> Animals	<input type="checkbox"/> Other: _____

• Check any **SYMPTOMS** that are felt **BEFORE** an asthma episode:

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Itching
<input type="checkbox"/> Other: _____	

• Check **SIGNS** that are usually present **DURING** an asthma attack:

<input type="checkbox"/> Coughing	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bluish color of skin/nails/lips
<input type="checkbox"/> Feel frightened	<input type="checkbox"/> Other: _____

• Does anyone who lives in the same household as the student smoke? Yes No

• Control of School Environment – List any environmental control measures and/or dietary restrictions to prevent an asthma episode _____

• Comments/Special Instructions _____

Parent/Guardian's Name (please print)

Parent/Guardian's Signature

Date