

# School District of Springfield Township Asthma Health History Form

It has come to our attention that your child has asthma or breathing problems. The school nurse needs more information on your child's asthma or breathing problems. This will help us take care of your child at school. **Please complete both sides of this form.**

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Preferred Home Phone Number (\_\_\_\_\_) \_\_\_\_\_

Who is your child's asthma health care provider? \_\_\_\_\_ Phone # \_\_\_\_\_

Child's age when diagnosed with asthma: \_\_\_\_\_ Date of last routine follow up visit for asthma: \_\_\_\_\_

How often does your child see your health care provider for routine asthma follow-up: \_\_\_\_\_

Name of Insurance \_\_\_\_\_. If none, do you want information on free / low cost insurance?  Yes  No

1. Please circle if your child's asthma is severe or not severe or anywhere in between (circle #):  1  2  3  4  5  
Not severe Severe

2. In general, in the past year has your child's asthma:  Improved  Stayed the same  Worsened

3. How many days did your child miss school **last year** due to his/her asthma?  
 0 days  1 – 2 days  3-5 days  6-9 days  10-14 days  15 or more days

4. How many times has your child been hospitalized overnight or longer for asthma in the **past 12 months**?  
 0 times  1 time  2 times  3 times  4 times  5 or more times

5. How many times has your child been treated in the Emergency Department for asthma in the **past 12 months**?  
 0 times  1 time  2 times  3 times  4 times  5 or more times

6. What triggers your child's asthma or makes it worse?  
 Smoke  Chalk / chalk dust  
 Animals / pets  Strong smells / perfume  
 Dust / dustmites  Foods (which ones: \_\_\_\_\_)  
 Cockroaches  Having a cold / respiratory illness  
 Grass / flowers  Stress or emotional upsets  
 Mold  Changes in weather / very cold or hot air  
 Exercise, sports, or playing hard

Does anybody in the household smoke?  Yes  No

7. For each season of the year, to what extent does your child usually have asthma symptoms? (Mark an X for each season below)

	A lot	A little	None		A lot	A little	None
Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. In the past month, during the day, how often has your child had a hard time with coughing, wheezing or breathing,?  
 2 times a week or less  More than 2 times a week  Every day (at least once every day)  Constantly (all of the time every day)

9. In the past month, during the night, how often does your child wake up or have a hard time with coughing, wheezing or breathing,?  
 2 times a month or less  More than 2 times a month  More than 2 times a week  Every night

10. Do you take your quick relief inhaler more than TWO times per week?  Yes  No

11. Do you refill your quick relief inhaler more than TWO times per year?  Yes  No

12. Please check your child's usual signs/symptoms of an asthma episode.  
 Wheezing  Shortness of breath  Difficulty breathing  Itchy throat  Coughing  Irritable  Chest tightness   
 Waking at night  Other: \_\_\_\_\_

13. Can your child identify the signs and symptoms of an asthma episode and can indicate when they need help  Yes  No  Don't know

14. Does your child have a written Asthma Action Plan?  Yes  No  Don't know

13. Does your child use a peak flow meter (something he/she blows into to check his/her lungs)?  Yes  No  Don't know

14. Do you know what your child's personal best peak flow number is?  Yes → what is it? \_\_\_\_\_  No

**Turn Page Over →**

15. Please list the medications your child takes for asthma or allergies (everyday and as needed) or **include a copy of your child's asthma action plan.**

**Medications Taken at Home**

Medication Name ?	How Much?	When is it Taken ?

**Medications to be Taken at School**

Medication Name ?	How Much?	When Should it be Taken ?

**I GIVE CONSENT FOR THE ADMINISTRATION OF THE ABOVE MEDICATIONS AT SCHOOL**

Parent/guardian signature \_\_\_\_\_

**\*I UNDERSTAND THAT I ALSO NEED SIGNED PERMISSION FROM MY CHILD'S HEALTH CARE PROVIDER TO ADMINISTER MEDICATION AT SCHOOL (a signed asthma action plan will suffice).**

16. How well does your child take his/her asthma medications?

- Can take medicine by self     Forgets to take medicine     Needs help taking medicine     Not using medicine now

17. Does your child usually use a spacer or holding chamber with his metered dose inhaler (a clear tube that attaches to the inhaler and better helps the inhaled medicine get into the lungs)?

- Yes     No     Don't know     He/she uses a dry powdered inhaler so he/she doesn't need a spacer

18. Do you find that your child's asthma care plan is effective?     Yes     No

Please explain \_\_\_\_\_

19. During the past year has your child's asthma ever stopped him/her from taking part in sports, recess, physical education or other school activities?

- Yes     No     Don't know

20. Please add anything else you would like us to know about your child's asthma

\_\_\_\_\_

Thank you for providing this information to help us provide the best care we can for your child. This information and your child's picture may be shared with school personnel who work directly with your child and when deemed necessary for your child's educational experience.

Please sign and return this form to your child's school nurse.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**M.I. = Mild Intermittent; Mi.P. = Mild Persistent; Mo.P. = Moderate Persistent; S.P. = Severe Persistent]**

Based on the:  
Manual for Managing Asthma in Minnesota Schools, Minnesota Department of Health (accessed 1/27/2016)  
Is the Asthma Action Plan Working?: Tool for School Nurse Assessment, (2008) National Association of School Nurses and National Asthma Education and Prevention Program.  
Guidelines for the Diagnosis and Management of Asthma, (2007). National Institute of Health  
 Originated: 1/2016

For office use only:	Student Symptom Severity assessment:
8. _____	Mi. _____
	Mi. P. _____
9. _____	Mo.P. _____
	S.P. _____