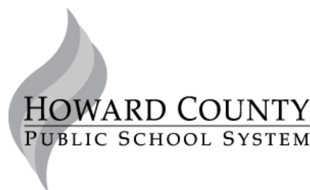

SCHOOL HEALTH SERVICES
ASTHMA HISTORY RECORD

DATE ________________________________

To The Parents/Guardian of ____________________________ Grade _______ Date of Birth ______________

Our records indicate that your child has asthma. In order for school personnel to respond to this health concern quickly and effectively, additional information concerning this condition would be helpful. The information you supply will be kept confidential and shared with staff on a need-to-know basis.

Please answer the following and circle where applicable:

1. When was the diagnosis made? ____
2. Do you consider the asthma condition serious or life threatening? YES NO
3. How many times has your child been hospitalized overnight or longer for asthma in the past year? __________
4. How often does your child have a severe episode? ________________________________
5. How many days would you estimate he/she missed school last year due to asthma? ______________________
6. What triggers your child's asthma attacks? ***(Please check any that apply)***

☐ Illness ☐ Emotions ☐ Medications ☐ Chemical odors

☐ Weather ☐ Exercise ☐ Foods ☐ Cigarette/Other smoke

☐ Fatigue ☐ Dust ☐ Cold/dry air

☐ Other ____

☐ Allergies ***(Please list)***______________________________________

7. Is your child receiving allergy shots? YES NO
8. What signs and symptoms does your child experience? ***(Please check all that apply)***

☐ Cough ☐ Wheeze ☐ Chest tightness ☐ Shortness of breath

☐ Difficulty breathing ☐ Rapid breathing ☐ Pale skin color ☐ Blue skin color

☐ Fatigue ☐ Difficulty walking/talking ☐ Sweating

☐ Anxiety, restlessness, and apprehension ☐ Nasal flaring and drawing in of neck and chest muscles

9. Please list the medications your child takes for asthma (everyday and as needed).

Name of Medication **Dose** **How Often**

(In School) ____

____

(At Home) ____

____

10. What side effects, if any, does your child have from taking his/her medications? ______________

____

<u>The Howard County School System does not encourage the routine administration of medication in the school setting</u>. However, if medication is necessary at school, a written health care provider's order and signed parent permission are required to be on file in the health room. Please consult with the health assistant or school nurse for forms and further information.

11. Does your child require medications by nebulizer at home? YES NO

12. Will your child be using a peak flow meter at school? YES NO

    What is your child's personal best peak flow reading? ______________________

13. Does your child require activity restrictions? YES NO

    Please describe: ______________________________________

    If your child requires activity restriction, the HCPSS form 3913040 – Physical Education/Activity Assessment Form – must be completed annually, by the health care provider, in order to be excused from certain curriculum.

14. Does your child understand asthma and what he/she should do to manage it? YES NO

15. How often is your child evaluated by the physician for asthma? ______________________
    Date of last visit ______________

16. Do you give permission for school personnel to contact the student's health care providers? YES NO

17. Pediatrician's Name ______________________ Phone ______________

    Specialist's Name ______________________ Phone ______________

PARENT SIGNATURE ______________________ **Date** ______________

Please share any **<u>ADDITIONAL INFORMATION</u>** with the School Nurse and Health Assistant below:

____

____

Would you like to be contacted by the School Nurse? YES NO

Contact Name ______________________________________

Contact Number ______________________ Best Time to Contact ______________

HEALTH ROOM USE ONLY

Form **Received** –Date: ______________	Form **Reviewed** –Date: ______________
Signed: ______________	Signed: ______________