Lakewood School District #306
P.O. Box 220 N. Lakewood, WA 98259
School Building Fax #: _____

ASTHMA HISTORY FORM

Student Name: _____ Birth Date: _____ Sex: M / F
School: _____ Teacher: _____ Grade: _____

You have indicated that your child may have asthma. In case your child has a minor asthma attack, we will provide basic first aid. If emergency treatment is needed, 911 will be called. By completing and returning this form, the school district can provide the best possible care of your child.

How long has your child had asthma? _____

I would rate my child's asthma as: (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

How many school days would you estimate your child missed last year due to asthma? _____

What triggers your child's asthma attacks? (Please check all that apply)

- ☐ Illness
- ☐ Exercise
- ☐ Foods
- ☐ Weather
- ☐ Allergies
- ☐ Odors
- ☐ Emotions
- ☐ Smoke
- ☐ Fatigue

Allergies (please list) _____
Other (please list) _____

What does your child do at home to relieve wheezing during an asthma attack? (Please check all that apply)

- ☐ Breathing exercise
- ☐ Inhaler
- ☐ Rest/relaxation
- ☐ Nebulizer
- ☐ Drinks liquids
- ☐ Oral medication

Other (please describe: _____

Please list the medications your child takes for asthma (everyday & as needed)

	Name of Medication	Dose	Frequency
In School:			
At Home:			

If medications are to be given during school, an authorization to administer medication form needs to be filled out yearly. Medications must be brought in by an adult and in the original labeled container.

If your child does not respond to medication, what action do you advise school personnel to take?
_____

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

Does your child know how to use an extension tube, pulmonary aid, or spacer with his/her inhaler? ☐ Yes ☐ No

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

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

Did a medical provider diagnose this? □ Yes □ No Date of Diagnosis: _____

How often does your child see his/her doctor for routine asthma evaluations? _____

Medical Provider's Name: _____ Phone #: _____

Last date seen: _____

Does your child need any special considerations related to his/her asthma while at school? (Describe briefly any that apply)

- □ Modified gym class _____
- □ Modified recess outside _____
- □ No animal pets in classroom _____
- □ Avoiding certain foods _____
- □ Emotional or behavior concerns _____
- □ Special consideration while on field trips _____
- □ Observation for side effects from medication _____
- □ Need to take medication at school _____
- □ Other _____

Have you ever attended an asthma education class? □ Yes □ No

Has your child had asthma education? □ Yes □ No

Thank you for your cooperation in planning for the safety of your child. Please call the nurse at your child's school if you have further questions or concerns.

_____	_____	_____	_____
Parent or Guardian Signature	Relationship	Telephone Number	Date