ASTHMA HISTORY **STUDENT NAME**_____ **DATE** _____

The following form will assist the school nurse and staff in determining any special needs for your child and the development of an individualized healthcare plan (IHP). This form is to be completed at initial IHP development and every 2 years thereafter. If you desire a conference with the school nurse, please call your child's school for an appointment.

1. **Does your child have a diagnosis of asthma from a healthcare provider:** ☐ No ☐ Yes
   Managing physician: _____ Phone:_____

2. **History of Current Status:**
   a) What are your child's triggers:

☐ **Exercise**	☐ **Foods:** _____	☐ **Vapors** _____	☐ **Pollen**
☐ **Respiratory Infections**	☐ **Animals:** _____	☐ **Change in temperature**	☐ **Dust**
☐ **Odors/Fumes**	☐ **Mold**	☐ **Other:** _____	

   b) Age of student when asthma was first diagnosed: _____
   c) Date of last asthma episode: _____ are the episodes: ☐ Same ☐ Better ☐ Worse
   d) How often does your child use their rescue inhaler: ☐ **Rarely** ☐ **Occasionally** ☐ **Monthly** ☐ **Weekly** ☐ **Daily**
   e) Ever been hospitalized due to asthma? ☐ **Yes** ☐ **No If yes, explain:** _____

3. **Trigger and Symptoms:**
   a. What are the early signs and symptoms of your student's asthma episode? *(Be specific; include things the student might say)* _____
   b. How does your child communicate his/her symptoms? _____
   b. How quickly do symptoms appear after trigger? Within: _____seconds ____ mins _____ hrs ____ days
   c. Please check the symptoms your child has experienced in the past:

General	Abdominal	Throat	Lungs	Heart
☐ **Trouble seeing caused by coughing, shortness of breath, wheezing**	☐ **Nausea**	☐ **Itching**	☐ **Shortness of breath**	☐ **Increased pulse**
☐ **Frequent respiratory infections**	☐ **Vomiting**	☐ **Tightness**	☐ **Repetitive Cough**	☐ **Loss of consciousness**
☐ **Delayed recovery of Bronchitis episodes**		☐ **Intermittent cough**	☐ **Whistling or wheezing when exhaling**	☐ **Chest pain**
☐ **Limited exercise because of shortness of breath**		☐ **Frequent cough**	☐ **Chest congestion**	
☐ **Fatigue/tired**			☐ **Chest tightness**	

4. **Treatment:**
   a. How is asthma being treated? _____
   b. What medication is the student taking (both daily and rescue)? _____
   c. How effective is the student's response to treatment? _____
   d. Has there ever been an emergency room visit? ☐ No ☐ Yes, explain:_____
   e. Was the student admitted to the hospital? ☐ No ☐ Yes, explain:_____
   f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes
   g. Have you used the treatment or medication? ☐ No ☐ Yes
   h. Please describe any side effects or problems your child had in using the suggested treatment:
   _____

****Continued on reverse**

5. **Self Care:**
   a. Is your student able to recognize and monitor their asthma symptoms? ☐ No ☐ Yes
   b. Does your student:
      1 Know what triggers to avoid……..... ☐ No ☐ Yes
      2 Communicate asthma symptoms……..... ☐ No ☐ Yes
      3 Tell an adult immediately when symptoms occur…… ☐ No ☐ Yes
      4 Wear a medical alert bracelet, necklace, watchband…… ☐ No ☐ Yes
      5 Tell peers and adults about their asthma…… ☐ No ☐ Yes
   c. Does your student know how to use their emergency medication? ☐ No ☐ Yes
   d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. **Family/Home**
   a. Does your child carry a rescue inhaler in the event of an asthma episode? ☐ No ☐Yes
   b. Has your child ever had to use a rescue inhaler? ☐ No ☐ Yes
   c. Do you feel that your child needs assistance in coping with his/her asthma? ☐ No ☐Yes

7. **General Health:**
   a. How is your child's general health other than having asthma? _____
   b. Does your child have other health conditions? _____
   c. Please add anything else you would like the school to know about your child's health: _____

8. **Notes:**

_____
_____
_____
_____
_____
_____
_____
_____

Parent/Guardian Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____