ANNUAL ASTHMA ASSESSMENT FORM

Gathering this information will assist in developing a health care plan for your child that will be shared with the educational team.

STUDENT NAME: ______________________Age: _____________

GRADE: ___________ TEACHER: ___________________________________

Treating Physician or Group: _______________________________________

Physician's Phone: ____

Medical Diagnosis: ____

Medications (at home and school): ___________________________________

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Known Allergies: ____

Describe your child's asthma:

Intermittent ____ Slow Onset ____ Sudden Onset ____Exercised-Induced ___

Other ____

Your child is able to communicate to an adult when having an asthma attack?

Yes ____ No____

How does your young child ask for their inhaler? _________________________

Does your child use a peak flow meter: Yes ____ No ____

Does your child use their inhaler: Dependently ____ With Assistance ____ With Supervision ____ Independently ____

What triggers your child's asthma?

Environmental ____ Cold Weather ____ Illness ____ Exercise ____

Seasonal____Other: ____

Will your child carry their inhaler or keep it in the health office or both?

____

Must have parental and physician medication form

Any restrictions from your physician? ___________________________________

When was your child diagnosed with asthma? ______________________________

When were your child's last asthma symptoms? _____________________________

How might your child's asthma affect school performance or participation in activities? ____

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Approximate school days lost last year due to asthma symptoms ___________

Additional comments: ____

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Parent Signature **Date**

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