



SIA HEALTH SERVICES
2706 E Queen • Spokane WA 99217 • Telephone (509) 209-8730 • Fax (509) 209-8078

ASTHMA INFORMATION FORM

Student's Name _____ Birthdate _____

School _____ Grade _____ Class (home) room _____

The following information is helpful to the nurse and school staff in determining any special needs for your child. If you desire a conference with the school nurse, please call for an appointment. Thank you for your assistance.

School Nurse _____ Phone _____

Please indicate which best describes your child's asthma:
<input type="checkbox"/> Asthma is no longer a health concern for my child.
<input type="checkbox"/> Asthma is a health concern for my child but is stable and does not require medication at school .
<input type="checkbox"/> Asthma is a health concern and requires medication at school . A School Asthma Plan will be required before student is able to attend school.

1. How long has your child had asthma? _____
2. Medications taken at home: _____
3. Medications taken during school (as needed medication): _____
4. **Check a box below that most accurately describes the current severity of your child's asthma.**

	Severity of Asthma	Symptoms	Nighttime Symptoms
<input type="checkbox"/>	Mild intermittent	Two or fewer times a week; no symptoms between episodes; brief episodes from a few hours to a few days and vary in intensity.	Two or fewer times a month
<input type="checkbox"/>	Mild persistent	Symptoms more than twice a week but less than once a day. Episodes may affect activity.	More than twice a month
<input type="checkbox"/>	Moderate persistent	Daily symptoms; daily use of short-acting inhalers. Episodes affect activity and occur at least twice a week and may last days	More than once a week
<input type="checkbox"/>	Severe persistent	Continual symptoms; limited physical activity; frequent episodes	Frequent

Please indicate what triggers your child's asthma:	Please indicate your child's early warning signs:
<input type="checkbox"/> Respiratory infection <input type="checkbox"/> Exercise <input type="checkbox"/> Emotions / stress <input type="checkbox"/> Cigarette smoke <input type="checkbox"/> Chemical odors <input type="checkbox"/> Medication <input type="checkbox"/> Foods <input type="checkbox"/> Allergies (list) _____ <input type="checkbox"/> Weather changes <input type="checkbox"/> Other (list) _____	<input type="checkbox"/> Cough <input type="checkbox"/> Cold symptoms <input type="checkbox"/> Drop in peak flow <input type="checkbox"/> Wheezing <input type="checkbox"/> Decreased exercise <input type="checkbox"/> Other (list) _____

Please check all special considerations related to your child's asthma that he/she will need while at school:	
<input type="checkbox"/> None <input type="checkbox"/> Avoiding strong smelling chemicals or irritants (chalk dust, sawdust, paint) <input type="checkbox"/> Modified recess or gym class <i>*Note from physician required</i> <input type="checkbox"/> Avoiding certain foods: _____	<input type="checkbox"/> Special considerations while on field trips <input type="checkbox"/> Special transportation to and from school* <i>*Note from physician recommended</i> <input type="checkbox"/> Avoiding animals/pets <input type="checkbox"/> Other _____

Parent/Guardian Signature: _____ Date: _____