NEWHALL SCHOOL DISTRICT

ASTHMA HISTORY FORM

Student Name:____ Date of Birth:__________________

Parent/Guardian: ____ Today's Date:__________________

Home Phone: ___________________Work:______________________ Cell:________________________

Healthcare Provider: _______________________________________ Phone: _________________________

When was this student's asthma first diagnosed?____

How many times has this student been seen in the emergency room for asthma in the past year?________________

How many times has this student been hospitalized for asthma in the past year?___________________________

What triggers this student's asthma?

☐ exercise ☐ respiratory infection ☐ strong odors or fumes

☐ carpets ☐ indoor dust ☐ outdoor dust

☐ chalk dust ☐ temperature changes ☐ molds

☐ wood smoke ☐ pollen ☐ stress

☐ animals (specify):____

☐ foods (specify):____

☐ other:____

What does this student do at home to relieve asthma symptoms? (check all that apply)

☐ breathing exercises ☐ rest/relaxation ☐ drinks liquids

☐ takes medications (see next page)

☐ other (please describe):____

____

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What medications does this student take for asthma (every day and as needed):

Medication Name	Amount	Delivery Method (nebulizer, inhaler, etc)	How Often
______________________	_________________	_________________________	__________________________
______________________	_________________	_________________________	__________________________
______________________	_________________	_________________________	__________________________

Does this student use any of the following aids for managing asthma?

☐ peak flow meter (personal best if known______________________)

☐ aero chamber ☐ spacer ☐ aero chamber w/mask ☐ nebulizer

☐ other:____

Has this student had asthma education? ☐ yes ☐ no

Would you like information about asthma education for: ☐ student ☐ self

Parent/Guardian Signature: ____ Date:______________________

Nurse Signature: ____ Date:______________________