School District of Springfield Township
Asthma Health History Form

It has come to our attention that your child has asthma or breathing problems. The school nurse needs more information on your child's asthma or breathing problems. This will help us take care of your child at school. **Please complete both sides of this form.**

Child's Name _____ Grade _____ School Year _____

Parent/Guardian _____ Preferred Home Phone Number (_____)_____

Who is your child's asthma health care provider? _____ Phone # _____

Child's age when diagnosed with asthma:_____Date of last routine follow up visit for asthma: _____

How often does your child see your health care provider for routine asthma follow-up:_____

Name of Insurance_____. If none, do you want information on free / low cost insurance? ☐ Yes ☐ No

1. Please circle if your child's asthma is severe or not severe or anywhere in between (circle #) : ☐1 ☐ 2 ☐3 ☐ 4 ☐ 5
   Not severe Severe
2. In general, in the past year has your child's asthma: ☐ Improved ☐ Stayed the same ☐ Worsened
3. How many days did your child miss school **last year** due to his/her asthma?
   ☐ 0 days ☐ 1 – 2 days ☐ 3-5 days ☐ 6-9 days ☐ 10-14 days ☐ 15 or more days
4. How many times has your child been hospitalized overnight or longer for asthma in the **past 12 months**?
   ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times
5. How many times has your child been treated in the Emergency Department for asthma in the **past 12 months**?
   ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times
6. What triggers your child's asthma or makes it worse?
   ☐ Smoke
   ☐ Animals / pets
   ☐ Dust / dustmites
   ☐ Cockroaches
   ☐ Grass / flowers
   ☐ Mold
   ☐ Chalk / chalk dust
   ☐ Strong smells / perfume
   ☐ Foods (which ones:_____)
   ☐ Having a cold / respiratory illness
   ☐ Stress or emotional upsets
   ☐ Changes in weather / very cold or hot air
   ☐ Exercise, sports, or playing hard

   Does anybody in the household smoke? ☐ Yes ☐ No
7. For each season of the year, to what extent does your child usually have asthma symptoms? (Mark an X for each season below)

	A lot	A little	None		A lot	A little	None
Fall	☐	☐	☐	Spring	☐	☐	☐
Winter	☐	☐	☐	Summer	☐	☐	☐

8. In the past month, during the day, how often has your child had a hard time with coughing, wheezing or breathing,?

   ☐ 2 times a week or less ☐ More than 2 times a week ☐ Every day (at least once every day) ☐ Constantly (all of the time every day)
9. In the past month, during the night, how often does your child wake up or have a hard time with coughing, wheezing or breathing,?

   ☐ 2 times a month or less ☐ More than 2 times a month ☐ More than 2 times a week ☐ Every night
10. Do you take your quick relief inhaler more than TWO times per week? ☐ Yes ☐ No
11. Do you refill your quick relief inhaler more than TWO times per year? ☐ Yes ☐ No
12. Please check your child''s usual signs/symptoms of an asthma episode.
    ☐ Wheezing ☐ Shortness of breath ☐ Difficulty breathing ☐ Itchy throat ☐ Coughing ☐ Irritable ☐ Chest tightness ☐

    Waking at night ☐ Other:_____
13. Can your child identify the signs and symptoms of an asthma episode and can indicate when they need help ☐ Yes ☐ No ☐ Don't know
14. Does your child have a written Asthma Action Plan? ☐ Yes ☐ No ☐ Don't know
13. Does your child use a peak flow meter (something he/she blows into to check his/her lungs)? ☐ Yes ☐ No ☐ Don't know
14. Do you know what your child's personal best peak flow number is? ☐ Yes → what is it? _____ ☐ No

Turn Page Over →

15. Please list the medications your child takes for asthma or allergies (everyday and as needed) **or <u>include a copy of your child's asthma action plan.</u>**

Medications Taken at Home

Medication Name ?	How Much?	When is it Taken ?

Medications to be Taken at School

Medication Name ?	How Much?	When Should it be Taken ?

I GIVE CONSENT FOR THE ADMINISTRATION OF THE ABOVE MEDICATIONS AT SCHOOL
Parent/guardian signature _____

***I UNDERSTAND THAT I ALSO NEED SIGNED PERMISSION FROM MY CHILD'S HEALTH CARE PROVIDER TO ADMINISTER MEDICATION AT SCHOOL (a signed asthma action plan will suffice).**

16. How well does your child take his/her asthma medications?

☐ Can take medicine by self ☐ Forgets to take medicine ☐ Needs help taking medicine ☐ Not using medicine now

17. Does your child usually use a spacer or holding chamber with his metered dose inhaler (a clear tube that attaches to the inhaler and better helps the inhaled medicine get into the lungs)?

☐ Yes ☐ No ☐ Don't know ☐ He/she uses a dry powdered inhaler so he/she doesn't need a spacer

18. Do you find that your child's asthma care plan is effective? ☐ Yes ☐ No

Please explain _____

19. During the past year has your child's asthma ever stopped him/her from taking part in sports, recess, physical education or other school activities?

☐ Yes ☐ No ☐ Don't know

20. Please add anything else you would like us to know about your child's asthma

_____

Thank you for providing this information to help us provide the best care we can for your child. This information and your child's picture may be shared with school personnel who work directly with your child and when deemed necessary for your child's educational experience.

Please sign and return this form to your child's school nurse.

Parent/Guardian Signature:_____ Date: _____

M.I. = Mild Intermittent; Mi.P. = Mild Persistent; Mo.P. = Moderate Persistent; S.P. = Severe Persistent]

Based on the:
<u>Manual for Managing Asthma in Minnesota Schools</u>. Minnesota Department of Health (accessed 1/27/2016)
<u>Is the Asthma Action Plan Working?: Tool for School Nurse Assessment</u>. (2008) National Association of School Nurses and National Asthma Education and Prevention Program.
<u>Guidelines for the Diagnosis and Management of Asthma.</u> (2007). National Institute of Health
Originated: 1/2016

<u>For office use only:</u>	<u>Student Symptom Severity assessment:</u>
8. _____	Mi. _____
	Mi. P. _____
9. _____	Mo.P _____
	S.P. _____