BLESSED SACRAMENT SCHOOL

ASTHMA HISTORY FORM

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Homeroom/Grade: _____

Home Phone: ( )_____ Work Phone: ( )_____

Health Care 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?_____

Has this student ever been admitted to an intensive care unit for asthma? _____

If so, when? _____

How would you rate the severity of this student's asthma?
(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

How many days would you estimate this student missed last year because of asthma? _____

What triggers this student's asthma? (check all that apply)

☐ exercise	☐ temperature change	☐ strong odors/fumes	☐ chalk dust
☐ respiratory infection	☐ dust	☐ stress	☐ wood smoke
☐ pollen	☐ molds	☐ carpets	☐ cigarette smoke

☐ animals (specify): _____

☐ foods (specify): _____

☐ other: _____

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

☐ breathing exercises	☐ rest/relaxation	☐ drinks fluids
☐ takes medication	☐ uses herbal remedies	

☐ other (please describe): _____

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

Medication Name	Dosage	Delivery Method (nebulizer, inhaler etc.)	Frequency

What herbal remedies, if any, does this student take for asthma? _____

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

☐ peak flow meter (personal best if known): _____

☐ spacer ☐ holding chamber ☐ holding chamber with mask

☐ other: _____

Please check special accommodations related to your child's asthma:

☐ physical education class ☐ recess ☐ animals in classroom

☐ avoidance of certain foods ☐ field trips ☐ special hydration needs

☐ other: _____

please provide details: _____

Parent/Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date: _____