ASTHMA HISTORY

Student Name:_____ **Grade** _____ **Date of Birth**:_____

Triggers:

- o Weather changes
- o Pollens
- o Foods:_____
- o Animals
- o Grasses
- o Exercise
- o Insect bites
- o Cold temperature
- o Flu or virus

Health Care Provider:

Name of Provider: _____ Phone number: _____

Date of last visit: _____

Health Benefits/Insurance: _____

Medications:

Name	**Dose**	**Is the medication taken daily?**

Does your child use a spacer? **Yes** **No**

Does your child use a Peak Flow Meter? **Yes** **No**

Has your child had treatment in the Emergency Room for asthma? __ Dates: ____

Has your child been hospitalized for asthma? _____ Dates: _____

Has your child been treated in the ICU for asthma? _____ Dates: _____

Do you want your child to have medication at school for asthma? **Yes** **No**

Parent Name: _____ Phone number: _____

Parent signature: _____ Date: _____

School Nurse signature: _____ Date: _____