



ASTHMA - STUDENT HEALTH HISTORY

Student Name		Grade		Date of Birth	
Healthcare Provider Name		Healthcare Provider Number			

HISTORY

1. How old was your child when diagnosed with asthma?				
2. Describe the symptoms your child has with a typical asthma episode (wheeze, cough, shortness of breath, etc)				
3. How does your child describe these symptoms?				
4. How frequently does your child experience each type of symptom? MILD (resolves quickly with rest or medication) MODERATE (requires a doctor visit to get things under control) SEVERE (requires a visit to the Emergency Room)	Times/Week	Times/Month	Times/Year	Never
5. Has your child ever been hospitalized for asthma? <input type="checkbox"/> yes <input type="checkbox"/> no If Yes, please give dates and explain:				
6. Identify the things which start an asthma episode. Check all that apply: <input type="checkbox"/> exercise <input type="checkbox"/> strong odors or fumes <input type="checkbox"/> animals <input type="checkbox"/> respiratory infections <input type="checkbox"/> chalk dust <input type="checkbox"/> dust <input type="checkbox"/> cold temperatures <input type="checkbox"/> sitting on a carpet <input type="checkbox"/> foods <input type="checkbox"/> hot temperatures <input type="checkbox"/> pollens <input type="checkbox"/> ozone alert days <input type="checkbox"/> change in temperature <input type="checkbox"/> mold <input type="checkbox"/> other _____				
Comments:				



CURRENT MANAGEMENT OF ASTHMA

7. How does your child understand his/her asthma and what he/she should do to manage it?			
8. Please list the medications your child takes routinely, the dosage, how often taken, when and under what circumstances additional doses may be given.			
MEDICATION	DOSAGE	HOW OFTEN	ADDITIONAL DOSES
9. Does your child suffer side effects from the medication? <input type="checkbox"/> yes <input type="checkbox"/> no			
If yes, please list medication and specific side effects.			
MEDICATION	SIDE EFFECTS		

SCHOOL ASTHMA ACTION PLAN/ASTHMA MEDICATIONS

Students with asthma must submit this Asthma-Student Health History (completed), an Asthma Treatment Plan (completed and signed by the student's doctor and signed by the parent on both sides), and the prescribed medication to the school nurse. All forms are available on the district website at <https://www.frsd.k12.nj.us/Page/108>

The district is required to keep an Asthma Action Plan on file for all students who require an asthma inhaler or nebulized medication here at school. An Asthma Action Plan includes information about medications, asthma triggers, and peak flow rates (if applicable) – important information for proper asthma management at both home and school.

All medications must be brought in by a parent and kept in the health office unless approval has been given by the health office and the student's physician for a student to self-carry an inhaler. If your child has permission to self-carry an inhaler, please send an extra one to be kept in the health office in the event your child forgets to bring it to school.

All medication forms (including asthma and allergy forms) are required to be updated and resubmitted each school year at the beginning of the year. Failure to do so may compromise our ability to safely care for your child. If you have any questions, please contact your child's school nurse.

PARENT/GUARDIAN SIGNATURE	DATE