

ASTHMA ASSESSMENT FORM FOR SCHOOL**Student's Name:** _____ **School Year:** _____**Date of Birth:** _____ **Grade:** _____ **School:** _____**Development of Disease**

How old was your student when they were diagnosed with Asthma? _____

Symptoms (check each box that describes your student's symptoms)

- ☐ Daytime Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Chest Tightness
- ☐ Mucous Production
- ☐ Nighttime Cough
- ☐ Nighttime Wheezing
- ☐ Interrupted Sleep Due to Symptoms
- ☐ Asking to Use Inhaler
- ☐ Other: _____

Asthma Triggers (check each box that describes your student's triggers)

- ☐ Exercise
- ☐ Cold Air
- ☐ Respiratory Illness/Colds
- ☐ Pollen
- ☐ Poor Air Quality
- ☐ Animal Dander
- ☐ Emotions (fear, crying, anger, laughing)
- ☐ Foods
- ☐ Medications
- ☐ Smoke, Chemicals, Strong Odors
- ☐ Other: _____

Current Medications

- ☐ Albuterol inhaler (Proair®, Ventolin HFA®, Proventil)
- ☐ Levalbuterol inhaler (Xopenex®)
- ☐ Allergy Medications (Name, Dose, Frequency): _____
- ☐ Other (please specify): _____

Does your student use a Peak Flow Meter? ☐ No ☐ Yes (Frequency, Current Readings) _____**Continue to next page**

Medication at School

Will your student use their inhaler at school, including sports, clubs, field trips, etc.? ☐ No ☐ Yes*
(*If yes, contact school nurse to complete the required medication authorization form)

Management/Treatment

How frequently does your student use their inhaler? _____

How many times in the last year has your student been treated for asthma in the doctor's office? Please describe.

How many times in the last year has your student been to the Emergency Room or hospitalized for asthma? Please describe. _____

Check the box that best describes your student's asthma symptoms:

☐ staying the same ☐ getting worse ☐ getting better

Student's Knowledge of Asthma Condition

Does your student understand their asthma triggers? ☐ No ☐ Yes

Can your student reliably report when they are experiencing distressing asthma symptoms? ☐ No ☐ Yes

Does your student know how to use their inhaler correctly? ☐ No ☐ Yes

Comments: _____

Parent/Guardian Signature

Date

Reviewed by Registered Nurse

Date

*Prior to attendance at school, each child with a life-threatening health condition shall present a medication or treatment order addressing the condition. A life-threatening health condition means a condition that will put the child in danger of death during the school day if a medication and/or treatment order and a nursing plan are not in place. Following submission of the medication or treatment order, a nursing plan shall be developed by the school nurse. Medication and treatment orders are required to be completed each school year. Students with a life-threatening health condition will be referred to the 504 Team for evaluation. (WAC 392-380-045, RCW 28A.210.320, SPS Superintendent Procedure 3413SP)