Asthma History

COLUMBIA PUBLIC SCHOOLS

Administration Building • 1818 W. Worley Street • Columbia, MO 65203

Complete only if student has asthma or history of asthma.
STUDENT_____ SCHOOL_____ GRADE _____

Dear Parent/Guardian:

Please provide your child's asthma information by completing this form and returning it to the school nurse.

1. Asthma continues to be a health concern for this student? _____Yes ____ No **If no, skip to box below.**
2. How long has this student had asthma? _____
3. What are the student's asthma triggers? _____
4. Has this student been hospitalized with asthma related problems in the last 3 years? ____Yes _____No
5. Has this student required urgent or emergency care due to asthma in the last 3 years? _____Yes ____No
6. Has this student been instructed to take daily medications to control asthma? _____ Yes _____No
   If so, what is the medication?_____
7. Has this student used asthma medications in the last year? _____Yes _____No
8. Will this student be carrying his/her inhaler at school? ____ Yes _____No **If yes, a Medication Self-Administration form must be completed and signed by the parent and healthcare provider.**
9. About how often does this student experience asthma symptoms? ____ 2 or more times per week
   ____ 2 or more times per month
   ____ 2 or more times per year
10. About how many days of school did this child miss last year due to asthma? _____
11. Physician my child sees for asthma: _____

If you answered Yes to any question 3-7, **the school must have a current Asthma Action Plan on file**. If your physician has already developed an asthma plan, please provide a copy to the school nurse. If not, obtain a form from the school nurse for you and your child's physician to complete. Return the form to the school nurse after your child's physician has completed it.

*****If your child no longer has a problem with asthma, carefully read the statement below. Initial the box if you agree with the statement, sign below and return this packet to the school nurse.** It is not necessary to complete an Asthma Action Plan**.**

☐ My child does not require daily medications to control asthma and has not used asthma medications in more than 1 year. My child has not required urgent or emergency care for asthma-related problems and has not been hospitalized for asthma-related problems in more than 3 years. Please change medical record to indicate my child has "History of Asthma."

My signature below verifies the information I have provided on this form to be accurate.

_____

Parent Signature and Date