Midland School
Asthma Assessment Form School Year _____

Student's Name _____ **Age**_____ **Grade/Class**_____

Doctor student sees for asthma _____ **Telephone** _____

1. At what age was your child diagnosed with asthma?_____

2. Please rate the severity of his/her asthma. (circle)

   (Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. How many days would you estimate he/she missed school last year due to asthma? _____

4. How many times has your child been hospitalized overnight or longer for asthma in the past year?

5. How many times has your child been treated in the emergency room for asthma in the past year?

6. How often does your child see his/her doctor for routine asthma evaluations?

7. What triggers your child's asthma attacks? (Please check any that apply).
   ___Illness ___Emotion___ Medications___ Foods ___Change of season ___ Pollen
   ___Weather ___Exercise___ Cigarette or other smoke ___Chemical Odors ___Fatigue

   Allergies (please list) _____

8. What does your child do at home to relieve wheezing during an asthma attack? (Please check any that apply)
   ___Breathing exercises Takes medication: ___Inhaler
   ___Rest/relaxation ___Nebulizer
   ___Drinks liquids ___Oral medication
   Other (please describe) _____

9. Please list the medications your child takes for asthma (everyday and as needed).

Name of Medication	Dose	Frequency
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

10. If your child does not respond to medication, what action do you advise school personnel to take?

11. Has your child been taught how to use an extension tube (aero chamber) with his/her inhaler? ____Yes ____No

12. Does your child need any special considerations related to his/her asthma while at school? Check any that apply and describe.
    ____ Modify gym class (doctor's note required)
    ____ Modify recess outside
    ____No animal pets in classroom
    ____Avoiding certain foods
    ____Emotional or behavioral concerns
    ____Special consideration while on field trips

Comment:_____

Please review assessment form, make any changes if needed, initial and date below, and return to the health office

Initial	Date	Initial	Date	Initial	Date	Initial	Date
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____