**Assessment Form: Asthma**

Date: _____

School: _____

Grade/Teacher: _____

<div align="center">

## Easton Arts Academy
*30 North 4<sup>th</sup> Street, Easton, Pennsylvania 18042*
*Phone (484) 546-4230   Fax (610) 829-6076*

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Dear parent/guardian of _____

According to our records, your student has a history of asthma or has shown
symptoms of asthma.  We would like to find out more about your student's
current health status so that we can provide better care.  Please complete
the questionnaire below.  I will be happy to schedule a meeting so that we can
discuss strategies to help minimize your student's problems with asthma at school.
Thank you for your help.  Feel free to call the school nurse for further assistance.
Sincerely,

School Nurse: _____        Daytime Phone Number: _____
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Name of asthma physican: _____        Phone: _____

May we contact the physician about your student's asthma?   Yes/No

When was your student diagnosed with asthma? _____

When was your student's last asthma attack? _____

What triggers an asthma attach? (Circle any applicable)

| | | | |
|---|---|---|---|
| Exercise | Infections | Food | Environmental Factors |
| Animals | Medications | Seasonal Factors | |

Allergies (list): _____

Irritants (list): _____

What medications does your student take for asthma?

Medication: _____        Dose: _____        Frequency: _____

Medication: _____        Dose: _____        Frequency: _____

Use of a peak flow meter?     Yes/No   If so, what is the normal reading? _____

Would you like your child to learn how to use a peak flow meter at school?

     Yes           No           Unsure

What signs/symptoms occur during an asthma attack? _____

_____

Last year, about how many days did you student miss school because of athsma? ____

How often does your student see the doctor each year because of asthma? _____

Has your student been hospitalized because of asthma? Yes/No

     If so, when? _____        How many times last year? _____

Has your student even been placed on a ventilator because of asthma? Yes/No

*Please note additional comments on the back of this form.  Thank you.*

Parent/Guardian Signature: _____        Date: _____

School Nurse Office Use Only:

Date Received: _____ CC: Health file/teacher file/parent or guardian/physician/case manager

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