BRADFORD COUNTY DISTRICT SCHOOLS and
BRADFORD COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

ASTHMA QUESTIONNAIRE/HISTORY

(To be completed by parent)

Name: _____D.O.B. _____ School Yr. _____ Grade:_____

Parent: _____Primary Phone # _____

Physician _____ Phone _____

Age of onset and diagnosis_____Medication Allergies:_____

Use of peak flow meter (frequency, current readings)_____

Use of any other aids for managing asthma (spacer, holding chamber, etc.)_____

When was the last time your child was seen by a physician for this condition(s)? _____

How many times has this student been seen in the emergency room in the past year for this condition(s)? _____

How many times has this student been hospitalized in the past year for this condition(s)? _____

Has this student ever been admitted to an intensive care unit for this condition(s)? _____

How many days would you estimate that this student missed from school or daycare last year for this condition(s)? _____

Medication Name	**Amount**	**Delivery Method (Nebulizer, etc.)**	**How Often**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Triggers and/or aggravating factors: ☐Exercise ☐Illness ☐Pollen ☐Smoke ☐Dust ☐Animals ☐Molds ☐Air Pollution ☐Cold Air ☐Grass ☐Foods(list) ☐Other(list)_____

Restrictions: (If your child may not participate in physical education activities, a doctor's note is required.) _____

_____

Field Trip Plan: _____

_____

Please add any additional information you feel is needed to safely care for your child: _____

_____

Authorization for Health Care Provider and School Nurse to Share Information:
I authorize my child's school nurse to assess my child in regards to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/ Guardian Signature _____Date _____

Notes _____

_____

Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Nurse Signature _____Date_____