Lake Washington School District

Lake Washington School District # 414
Asthma Assessment Form

Student's name____________________________________ Date of birth _________________________

School ________________________________ Grade ________ Teacher _________________________

Parent/Guardian(s) name ____

Home phone____________________ Work phone________________ Cell phone___________________

Parent/Guardian email ____

1. How long has your child had asthma?____

2. Approximately how many days, last year, was your child absent due to asthma? ______________

3. How many times in the past has your child been:

   A. hospitalized overnight or longer for asthma? ______________
   B. treated in an emergency room for asthma? _______________
   C. treated in a doctor's office for non-routine asthma? ________

4. What triggers your child's asthma episodes? (Check all that apply) Also, please put a * next to any new triggers found within the past 12 months.

   ___ respiratory infections ___ foods ___ exercise ___ weather changes
   ___ emotions ___cigarette smoke ___medication ___ chemical odors

   ___ allergies (list) ____

   ___ other (list) ____

5. What are your child's early warning signs of an asthma episode? (Check all that apply)

   ___ cough ___cold symptoms ___wheezing ___decreased tolerance to exercise
   ___ other (list) ____

6. Does your child recognize the symptoms of an asthma episode and know what to do about it?
   ___ yes ___ no

7. Please list all medication your child takes for asthma. Please indicate if taken daily or as needed

Name of medication	**Dose & Time taken**	**Route (oral, inhaler, nebulizer)**

8. How many times has your child taken oral/injected steroids (Prednisone, Prednisolone, Dexamethasone) in the past year? ____________

9. What, if any, side effects does your child have from his/her asthma medication? ________________

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10. Name of practitioner treating your child's asthma ____
Office location ____________________________ Phone _______________________________

If your child has emergency asthma medication at home, he/she will need a supply at school as well.

- **FORMS NEEDED**: Asthma Emergency Health Plan
  Authorization to Administer Medication at School (1 for each medication)
- The health care practitioner and parent/guardian are required to sign/date **each** medication authorization form. **Physician name stamps are not accepted**.
- Once these are completed, please return them with appropriate medication to the school secretary. *New forms are required at the beginning of every school year.*

I authorize this information to be shared with teachers and school staff.

Parent/Guardian Signature: ____

Print Name ____ Relationship to student ________________

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