



## Asthma Information Sheet

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_

Physician treating child's asthma: \_\_\_\_\_ Phone: \_\_\_\_\_

Approximately how often does your child have an asthma attack? \_\_\_\_\_

When was the last attack? \_\_\_\_\_

### Asthma Symptoms:

Do any of the following trigger an asthma attack in your child:

- |   |   |
|---|---|
| <input type="checkbox"/> Exercise                       | <input type="checkbox"/> Strong odors or perfumes |
| <input type="checkbox"/> Respiratory infections         | <input type="checkbox"/> Chalk dust               |
| <input type="checkbox"/> Changes in temperature/weather | <input type="checkbox"/> Carpeting                |
| <input type="checkbox"/> Animals                        | <input type="checkbox"/> Pollens                  |
| <input type="checkbox"/> Food _____                     | <input type="checkbox"/> Molds                    |
| <input type="checkbox"/> Other: _____                   |   |

Can your child identify early warning signs of an asthma attack?  Yes  No

If yes, please describe signs. \_\_\_\_\_

### Treatment

Does your child routinely use an inhaler before exercise?  Yes  No

Does your child routinely use an inhaler or other preventative medications?  Yes  No

If yes, does your child use a spacer or holding chamber with his/her inhaler?  Yes  No

Does your child have side effects from these medications?  Yes  No

If yes, please explain. \_\_\_\_\_

Does your child understand asthma and what he/she should do to manage the condition?  Yes  No

Additional comments: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_