

Shorecrest | Be More

Shorecrest Preparatory School Asthma Student Health History Form

Student Name: _____ DOB: _____

Grade: _____ Allergies: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Diagnosing/treating physician: _____ Phone: _____

ASTHMA

Description of Condition: Asthma/ Reactive Airway Disease is a chronic inflammatory disease of the bronchial tubes characterized by episodes of constriction and increased mucous production by trachea and bronchi over-reacting to various stimuli and triggers. During an asthma episode, the airways become narrowed or blocked, making it difficult to breathe. Coughing, wheezing and tightening of the chest may also occur. Bronchodilators are used to increase airway and corticosteroids are used to reduce the inflammatory response.

Uses Spacer Yes No (If yes, spacer must be provided to the school)

Student will: (please check appropriate box below)

- Keep inhaler in clinic
- Carry inhaler at school and will need assistance with administration of inhaler.
- Carry inhaler at school and self-administer. **Students who self-carry their inhaler must complete an Authorization to Carry and Self-Administer Form.**

Special dietary needs or restrictions _____

Asthma triggers (check all that apply):

- Exercise
- Pollens
- Respiratory infections
- Change in temperature
- Strong odors
- Other: _____
- Molds
- Emotions
- Carpets
- Animals _____

Asthma episodes signs and symptoms: (check all that apply)

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Short of breath | <input type="checkbox"/> Ear pain |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Tight throat | <input type="checkbox"/> Itchy |
| <input type="checkbox"/> Tight chest | <input type="checkbox"/> Tired, weak |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Hot |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Shaky |
| <input type="checkbox"/> Other _____ | |

MEDICATIONS: Include all medications taken every day and taken only as needed.

Name of Medication	Dose	Times Given	Side Effects

The goal is to establish and maintain a healthy environment for your child. We cannot stress enough the importance of having current telephone numbers, including emergency numbers. If your child is in medical distress and shows no signs of improvement, 911 will be called.

I give permission for release of medical information contained in the Student Health History Form to be shared with school staff as needed, to maintain a healthy school environment for my child. I also give permission for the school nurse and Health Care Provider who is _____ and whose phone number is _____, to communicate verbally or in writing to provide continuity for my child.

X _____
Parent/Guardian's Signature

Date

X _____
Nurse's Signature

Date