

ASTHMA HISTORY FORM (continued)

What medications does this student take for asthma (every day and as needed):

Medication Name	Amount	Delivery Method (nebulizer, inhaler, etc.)	How Often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What herbal remedies, if any, does this student take for asthma? _____

Does this student use any of the following aids for managing asthma?

- peak flow meter (personal best if known _____)
- holding chamber spacer holding chamber w/mask
- other: _____

Please check special needs related to your child's asthma:

- physical education class recess animals in classroom
- avoidance of certain foods field trips access to water
- transportation to and from school other
- observation of side effects from medications

If you checked any of the above special needs boxes, please describe needs:

Has this student had asthma education? yes no

Would you like information about asthma education for: student self

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____