

School Asthma History and Needs Assessment

Student Name: _____ Teacher/Team _____

How long has your child had asthma? _____

What signs and symptoms signal a flare of your child's asthma? _____

Do you wish to have your child's peak flow measured at school? Yes No

(If yes, peak flow meter must be provided by parent.)

How many times has your child been taken to the ER due to asthma? _____

How many days of school did your child miss last year due to asthma? _____

I rate my child's need to improve self-management of asthma (use of inhaler, peak flow meter, symptom reporting) as:

0-None 1-Low 2-Moderate 3-High

I rate the severity of my child's asthma currently as:

0-None 1-Low 2-Moderate 3-High

Parent/Guardian Signature _____ Date _____

Health Room Staff Signature _____ Date _____

Moderate to High rating of asthma needs, indicates an Asthma Action Plan for this student.