BLUE SPRINGS R-IV SCHOOL DISTRICT

ANNUAL ASTHMA UPDATE

Student Name:	D.O.B:	Grade:
School:	Date:	

Does Asthma continue to be a health concern for your student? (Please Check) ☐ Yes ☐ No

Rate your students severity of asthma (Please Check) Mild [☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5] Severe

List the name of your students rescue inhaler:

Asthma Symptoms (Please check): ☐ Cough ☐ Wheezing ☐ Shortness of Air ☐ Chest Tightnesss
List Other:

Asthma Triggers (Please Check): ☐ Respiratory Infection ☐ Pollens/Mold ☐ Smoke ☐ Exercise
Temperature Changes ☐ Dust ☐ Cold Air ☐ Strong Odors or Fumes ☐ Animals (List):
Foods (List):

CLINIC USE ONLY
BASELINE PEAK FLOW: **FEV1**

Please complete the following questions:

☐ YES	☐ NO	Does your student take daily asthma medication(s)? Please list medication oral and/or inhaled:
☐ YES	☐ NO	Does your student have Asthma symptoms two or times a week that requires the use of a rescue inhaler? List symptoms:
☐ YES	☐ NO	Has your student had more than one **severe** Asthma flare-up that required the use of a steroid in the last 12 months? (Prednisone, Prelone, Medrol)
If you answered yes to any of the above questions, please continue with the questions below.		
☐ YES	☐ NO	Does your student have symptoms of coughing, wheezing, and breathing difficulty, chest tightening or waking at night more than once a week on **a regular basis?** List Symptoms:
☐ YES	☐ NO	Does your student miss school due to Asthma? If yes, how often do they miss school: times a week/ times a month/ during the Spring during the Fall
☐ YES	☐ NO	Does your student have difficulty participating in school activities? List activity(s):
☐ YES	☐ NO	Does your student have problems with side effects from their Asthma medication? List side effects:
☐ YES	☐ NO	Has your student had any emergency room/hospital visits related to their asthma in the last 12 months? List approx.. date of visit :
☐ YES	☐ NO	Does your student take daily asthma medication(s)? Please list medication oral and/or inhaled:
☐ YES	☐ NO	Does your student miss more than one hour of class time in a week for **Asthma** related interventions/treatments/symptoms?

Date	**Parent/Guardian Signature**	**Relationship to Student**