Seattle Public Schools

ASTHMA ASSESSMENT FORM FOR SCHOOL

Student's Name: _____ **School Year:** _____

Date of Birth: _____ **Grade:** _____ **School:** _____

Development of Disease

How old was your student when they were diagnosed with Asthma? _____

Symptoms (check each box that describes your student's symptoms)

☐ Daytime Cough
☐ Wheezing
☐ Shortness of Breath
☐ Chest Tightness
☐ Mucous Production
☐ Nighttime Cough
☐ Nighttime Wheezing
☐ Interrupted Sleep Due to Symptoms
☐ Asking to Use Inhaler
☐ Other: _____

Asthma Triggers (check each box that desribes your student's triggers)

☐ Exercise
☐ Cold Air
☐ Respiratory Illness/Colds
☐ Pollen
☐ Poor Air Quality
☐ Animal Dander
☐ Emotions (fear, crying, anger, laughing)
☐ Foods
☐ Medications
☐ Smoke, Chemicals, Strong Odors
☐ Other: _____

Current Medications

☐ Albuterol inhaler (Proair®, Ventolin HFA®, Proventil)
☐ Levalbuterol inhaler (Xopenex®)
☐ Allergy Medications (Name, Dose, Frequency): _____
☐ Other (please specify): _____

Does your student use a Peak Flow Meter? ☐ No ☐ Yes (Frequency, Current Readings) _____

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Medication at School

Will your student use their inhaler at school, including sports, clubs, field trips, etc.? ☐ No ☐ Yes*****

(*If yes, contact school nurse to complete the required medication authorization form)

Management/Treatment

How frequently does your student use their inhaler? _____

How many times in the last year has your student been treated for asthma in the doctor's office? Please describe.

_____

How many times in the last year has your student been to the Emergency Room or hospitalized for asthma? Please describe. _____

Check the box that best describes your student's asthma symptoms:

☐ staying the same ☐ getting worse ☐ getting better

Student's Knowledge of Asthma Condition

Does your student understand their asthma triggers? ☐ No ☐ Yes

Can your student reliably report when they are experiencing distressing asthma symptoms? ☐ No ☐ Yes

Does your student know how to use their inhaler correctly? ☐ No ☐ Yes

Comments: _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Reviewed by Registered Nurse Date

*Prior to attendance at school, each child with a life-threatening health condition shall present a medication or treatment order addressing the condition. A life-threatening health condition means a condition that will put the child in danger of death during the school day if a medication and/or treatment order and a nursing plan are not in place. Following submission of the medication or treatment order, a nursing plan shall be developed by the school nurse. Medication and treatment orders are required to be completed each school year. Students with a life-threatening health condition will be referred to the 504 Team for evaluation. (WAC 392-380-045, RCW 28A.210.320, SPS Superintendent Procedure 3413SP)