Saint Ignatius College Prep
ANNUAL ASTHMA ASSESSMENT

Student Name: _____ Class of 20 _____

Dear Parent/Guardian of: _____

According to our records, your child has a history of asthma. In order for school personnel to better understand his/her current status, please complete the following questionnaire. Thank you and please feel free to call if I can be of further assistance.

Sincerely,
Margie Balogh BSN, RN PEL-CSN (312) 432-8331

PLEASE SUPPLY THE FOLLOWING INFORMATION:

How often does your student see the physician for his/her asthma?
_____

When was your student first diagnosed with asthma? (give age or year)
_____

Is your student still bothered by asthma? ☐No ☐Yes If yes, please explain:

_____

Has your student ever been hospitalized for asthma? _____ If yes, please explain:
_____
_____

What triggers an asthma episode (check all that apply)?

☐ Food	☐ Allergies	☐ Infections
☐ Drugs	☐ Exercise	☐ Animal dander
☐ Weather	☐ Irritants	☐ Colds/Upper Respiratory Infection
☐ Other: _____		

Please list all the medications your child takes at home and school for his/her asthma.

Name_____	Name_____	Name_____
Dose _____	Dose _____	Dose _____
Frequency _____	Frequency _____	Frequency _____
A ☐rescue ☐preventative medicine	A ☐rescue ☐preventative medicine	A ☐rescue ☐preventative medicine

Does your student use a peak flow meter? ☐Yes ☐No Best Reading_____

How often does your child have asthma symptoms during the **DAY**?
☐ Less than 2 times a week ☐ Daily ☐ More than 2 times a week ☐ Continual

How often does your child have asthma symptoms during the **NIGHT**?
☐ Less than 2 times a month ☐ More than 3-4 times a month
☐ More than 5 times a month ☐ Continual

Will your child require medication to be available at school for treatment of asthma?

☐Yes ☐No

If YES, please complete the required medication/self –administration form with required parent and physician signatures.

Parent Name: _____Home Phone: _____

Work Phone: _____ Cell Phone:_____

Parent Signature: _____ Date: _____