THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA and
FLORIDA DEPARTMENT OF HEALTH IN SARASOTA COUNTY
SCHOOL HEALTH SERVICES
1960 LANDINGS BOULEVARD, SARASOTA, FL 34231 PHONE (941) 927-9000

ASTHMA HISTORY

Instructions: Return this completed form to the school health room by _____

Student Name _____ DOB _____

School _____ Grade _____ Date _____

1. Has your child ever been diagnosed by a physician or hospitalized for asthma? ☐ Yes ☐ No
   If yes, name of physician treating child's asthma _____
   Physician Phone No. _____
2. Approximately how often does your child have an asthma attack? _____
3. When was the last attack? _____
4. What triggers your child's asthma or makes it worse? _____
5. Does exercise cause an asthma attack? ☐ Yes ☐ No (If Yes, explain) _____
6. Does weather affect your child's asthma? ☐ Yes ☐ No (If Yes, explain) _____
7. What are your child's asthma symptoms? _____
8. Name the medication(s) taken routinely, the dosage, and how often they are to be taken by your child in school. (If medications are to be taken by your child in school, we must have a Medication/Treatment Authorization Form on file.)
9. Does your child have side effects from these medications? ☐ Yes ☐ No (If Yes, explain) _____
10. Does your child usually use a spacer or holding chamber with his/her metered dose inhaler (a clear tube that attaches to the inhaler and better helps the inhaled medicine get into the lungs)? ☐ Yes ☐ No ☐ Don't know
11. Does your child understand asthma and what he/she should do to manage the condition? ☐ Yes ☐ No
    (If Yes, explain) _____
12. Does your child use a peak flow meter (something he/she blows into to check his/her airway)?
    ☐ Yes ☐ No ☐ Don't know. If Yes, what is your child's personal best peak flow number? _____

Comments _____

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____ Date _____