AUBURN UNION SCHOOL DISTRICT
255 EPPERLE LANE
AUBURN, CA 95603
PHONE 530.885.7242 FAX 885.5170

ASTHMA INFORMATION

Dear Parent/Guardian,
According to your child's health records, he/she has asthma. To best assist us in anticipating and treating any asthma issues, please complete and return this form. If you child takes medication for asthma, please have your health care provider complete an *Asthma Action Plan*. If you have any questions, please contact Jenny Serrano, District Nurse (jserrano@auburn.k12.ca.us)

Student Name:		**Date of Birth:**
School:	**Grade**	**School Year:**

What are some triggers that might start an asthma episode for your student?

☐Exercise ☐Pollens ☐Irritants (e.g. chalk dust) ☐Cigarette Smoke
☐Animal Dander ☐Molds ☐Emotions (e.g. when upset) ☐Strong Odors
☐Respiratory Infections ☐Temperature Changes ☐Foods: ☐Other:

How severe and frequent are your child's asthma problems?

☐ Mild ☐ Moderate ☐ Severe

How old was your child when he/she started having asthma?

What are your child's usual signs/symptoms during an asthma attack?

☐ Wheezing ☐ Cough ☐ Difficulty breathing ☐ Chest tightness ☐ Anxiety ☐ Other:

How many days of school would you estimate your child has missed last year due to asthma?

In the past year, how many times has your child been treated in the emergency room for asthma symptoms?

In the past year, how many times has your child been hospitalized (overnight or longer) for asthma symptoms?

In the past month, during the day, how often has your child had asthma symptoms?

In the past month, during the night, how often does your child wake up with/experience asthma symptoms?

What does your child do at home to relieve the symptoms during an attack?

☐ Rests ☐ Drinks fluids ☐ Uses breathing exercises ☐ Checks peak flow ☐ Takes medication ☐ Other:

Does your child use a peak flow meter? ☐**YES** ☐ **NO**

If yes, what is your child's personal best peak flow reading? ________________________

Does your child take medication for asthma on a regular basis? ☐**YES** ☐ **NO**

If yes, please list medication(s) on next page

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ASTHMA INFORMATION
(CONTINUED)

PLEASE NOTE: *A supply of your child's medication may be kept at school (or on your child's person if it is a rescue medication) for emergency use, but only if a* ***"Medication in School"*** *or "**Asthma Action Plan"** form has been completed by your health care provider and submitted to the District Nurse.*

MEDICATIONS				
Medication	***Dose***	***Route***	***Time***	***Reason***

Is there any other information you would like to share with the District Nurse?

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Signature of Parent/Guardian____ **Date**__________

*****PLEASE COMPLETE AND RETURN TO SCHOOL HEALTH OFFICE*****

• FOR HEALTH OFFICE USE ONLY •

Date Received: ☐**Follow Up Needed** ☐**ISHP Completed**