VALOR EDUCATION

Asthma Information from Parent

Student's name _____ Birthdate _____ School _____ Teacher _____

Parent/Guardian _____ Phone (H) _____ Phone (W) _____ Phone (C) _____

Parent/Guardian _____ Phone (H) _____ Phone (W) _____ Phone (C) _____

Emergency contact _____ Relationship _____ Phone _____

Physician/Clinic _____ Phone (Office) _____

Does your child see another physician/clinic for asthma (If yes, please complete doctor information)? ■Yes □No

Physician/Clinic _____ Phone (Office) _____

List all medications: Home: _____

School: _____

What triggers your child's asthma attack? (Check all that apply)

- ☐ Insect Bites/Stings
- ☐ Dust/Dust Mites
- ☐ Exercise
- ☐ Pest/Roaches
- ☐ Cold air
- ☐ Strong odors, perfume, cleaning products
- ☐ Cigarette smoke
- ☐ Stuffed Animals
- ☐ Mold
- ☐ Pets
- ☐ Weather changes
- ☐ Foods: _____
- ☐ Colds/Flu/Illness
- ☐ Carpet
- ☐ Ozone alert days
- ☐ Plants, flowers, cut grass, pollen
- ☐ Wood smoke
- ☐ Emotion
- ☐ Other: _____

Does student have an EpiPen? ■Yes □No

Describe the symptoms your child experiences before or during an asthma episode. (Check all that apply)

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ "Tightness" in chest
- ☐ Breathing hard and fast
- ☐ Runny nose
- ☐ Rubbing chin/neck
- ☐ Feeling weak/tired
- ☐ Other: _____

How many years has your child had asthma? ___ /year(s) or ___ /month(s)

How often does your child wheeze or cough? ___ /week or ___ /month

Does your child have nighttime coughing or wheezing? □Yes ■No If yes, how often? ___ /week ___ /month

What does your child do at home to relieve breathing difficulties during an asthma attack?

Rest/relaxation ☐ Drinks/liquids ☐ Medications ☐ Other: _____

Authorization for release of Medical Information:

I hereby authorize _____ to furnish asthma-related information regarding
Clinic/Provider

my child _____ to the Clinic personnel at _____.
Student's Name School Campus

_____ _____ _____
Parent/Guardian Signature Print Name Date

I give permission for the school nurse to communicate with my child's doctor concerning their asthma and treatment.

_____ _____ _____
Parent/Guardian Signature Print Name Date