Asthma Intake Form

DOES YOUR CHILD HAVE ASTHMA?
☒ No – STOP HERE
☐ Yes – Please complete this form
If you have any questions, please contact your child’s school nurse.
Date form completed: __________________________  Student Name: __________________________

Parent/Guardian Name & Phone #: __________________________

Date form completed: __________________________

If you have any questions, please contact your child's school nurse.

DOES YOUR CHILD HAVE ASTHMA?
☐ Yes
☐ No

Medicines Used for Asthma

<table>
<thead>
<tr>
<th>List Names or Colors of Medicines Used for Asthma</th>
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What triggers your child’s asthma? (Check all that apply)

- Illness (colds)
- Smoke
- Allergies: Cat, Dog, Dust, Mold, Pollen
- Emotions (crying, laughing, stress)
- Exercise/physical activity
- Food: __________________
- Weather changes
- Strong odors/smells
- Other: __________________

10. Please write the names or colors of medicines (inhalers/puffers, pills, liquids, nebulizers) your child takes for asthma and allergies (the ones every day and as needed) and give the nurse a copy of your written asthma treatment plan.

11. How well does your child take asthma medicines? (Only one answer)
   • Takes medicine by self
   • Needs help taking medicine
   • Not using medicine now

Parent Signature: __________________________ Date: __________________________

School Nurse Reviewed: __________________________ Date: __________________________