Dumont Public Schools
Nursing Department

ASTHMA ASSESSMENT

Student's name: _____ Age: _____ Grade: _____ School: _____
Address: _____
Parent/Guardian name: _____ Telephone number (H) _____
(Cell) _____ (Work) _____

Emergency Phone Contact #1 _____ Phone #: _____
Name
Emergency Phone Contact #2 _____ Phone # _____
Name

Physician Student Sees for Asthma: _____ Phone # _____
Other Physician: _____ Phone # _____

Daily Asthma Management Plan

1. How long has your child had asthma? _____

2. Please rate the severity of his/her asthma? (circle)
(Not severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. How many days would you estimate he/she missed last school year due to asthma? _____

4. What triggers your child's asthma attack? (Please check all that apply?
_____Illness _____Emotions _____Medications _____Foods _____Fatigue
_____Weather _____Exercise _____Cigarette/ other smoke _____Chemical odors

5. What does your child do at home to relieve wheezing during as asthma attack? (Please check all that apply.)
_____Breathing exercises Takes medication: _____Inhaler
_____Rest/relaxation _____Nebulizer
_____Drinks liquids _____Oral medication
_____Other (please describe)_____

Daily Medication Plan

	Name	Dose
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Comments/Special Medication: _____

Parent/Guardian Signature:_____ **Date:**_____

Revised 5/17