# STUDENT ASTHMA HISTORY

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| **STUDENT**<br>Student Name and DOB | |
| **SEVERITY**<br>Is your child's asthma mild, moderate, or severe? | |
| **FREQUENCY**<br>**Is your child's asthma intermittent (not daily) or persistent (daily)** | |
| **TRIGGERS**<br>**What triggers your child's asthma?** | ☐ Smoke ☐ Dust ☐ Acid Reflux ☐ Exercise ☐ Mold/Mildew ☐ Stress<br>☐ Illness ☐ Allergens ☐ Animals ☐ Other: |
| **TYPE OF SYMPTOMS**<br>Tell me about what type of symptoms your child experiences. | ☐ Wheezing ☐ Persistent coughing ☐ Severe coughing<br>☐ Difficulty breathing ☐ Shortness of breath ☐ Tightness in chest<br>☐ Other (describe:) |
| **ONSET**<br>When was your child diagnosed with asthma? | |
| **FREQUENCY**<br>How often does your child experience asthma reactions? | |
| **MAINTENANCE**<br>Does your child take daily maintenance medication to control asthma? | |
| **RESCUE MEDICATION**<br>What does your child use for rescue medication? | |
| **HISTORY**<br>Has your child required emergency care or hospitalization for asthma? | |
| **PROVIDER**<br>Who is your child's asthma specialist, allergist, or immunologist? | |
| **ACCOMODATIONS**<br>Does your child require any accommodations related to asthma? | |
| **RESTRICTIONS**<br>**Does your child have any restrictions related to asthma?** | |
| **FORM COMPLETION**<br>Who completed this form?<br>Date? | |