Guadalupe Union School District
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: ______ School: ______

Student Name: ______ Birth date: ______

Parent/Guardian Name & Phone #: ______

Health Care Provider for asthma (name & phone #): ______

1. In the past 12 months, how many times has your child visited the ER/urgent care or had an urgent doctor's office visit for asthma?

☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

2. In the past 12 months, how many times has your child been hospitalized overnight for asthma?

☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

3. In the past 12 months, how many times has your child used oral steroids (prednisone, Orapred) to treat an asthma attack

☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

4. How many days of school did your child miss this past school year because of asthma?

☐ 0 days ☐ 1-2 days ☐ 3-5 days ☐ 6-10 days ☐ 11-15 days ☐ 15 or more days

5. In the past 4 weeks, how often has your child used a rescue or reliever medicine (a syrup, inhaler, or breathing machine) to relieve coughing, trouble breathing, or wheezing?

☐ Never ☐ 1-2 days/week ☐ 3 or more days/week but not every day ☐ Every day

6. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day?

☐ Never ☐ 1-2 days/week ☐ 3 or more days/week but not every day ☐ Every day

7. In the past 4 weeks, how often has your child awakened at night because of coughing, trouble breathing, or wheezing?

☐ Never ☐ 1-2 times/month ☐ 3 or more times/month ☐ 2 or more times/week ☐ Every night

8. In the past 4 weeks, how often has your child's asthma bothered or interrupted him/her during normal activities (playing, running around, and sports)?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ All of the time

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

☐ Illness (colds) ☐ Smoke ☐ Weather changes ☐ Strong odors/Smells

☐ Allergies: ☐ Cat ☐ Dog ☐ Dust ☐ Mold ☐ Fungus ☐ Pollen

☐ Exercise/Physical Activity ☐ Emotions (crying, laughing, stress) 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.

List names of medications used for Asthma: ______

11. How well does your child take asthma medicines? (Only one answer)

☐ Takes medicine by self ☐ Needs help taking medicine ☐ Not using medicine now

School Nurse Reviewed: ______ Date: ______