

Asthma Assessment Tool

NAME:		SCHOOL:	
STUDENT NUMBER:		GRADE:	
DATE OF BIRTH:		DATE:	

1. Does your child have a current diagnosis of asthma (i.e., have they seen a provider for asthma within the last year)? *

Mark only one oval.

Yes No

2. Who manages your child's asthma (doctor's name)? *

3. Does your child have a current Asthma Action Plan from this provider? *

Mark only one oval.

Yes No

4. When was the last time your child had asthma symptoms and used their inhaler? *

Mark only one oval.

Within the last week Within the last month Within the last 3 months
 Within the last 6 months Within the last year >1 year

5. How severe is your child's asthma?

Mark only one oval.

Mild Moderate Severe

6. How frequent are your child's asthma symptoms? *

Mark only one oval.

Intermittent (not daily)

Persistent (daily)

7. What are your child's asthma triggers? *

Check all that apply.

Allergies

Smoke

Dust

Acid

Reflux

Exercise

Mold

Stress

Illness

Other: _____

8. What symptoms does your student typically have during an asthma flare up? *

Mark only one oval.

Shortness of Breath

Wheezing

Severe

Coughing Chest

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This document was adapted from resources generously shared by the **Beaverton School District**. We appreciate their collaboration and support.

Tightness

Other: _____

9. Has there been a recent change in your child's asthma (e.g., symptoms are becoming more frequent)? *

Mark only one oval.

Yes No

10. If you answered "YES" to the above question, please explain

11. Does your student have any other health conditions (such as food allergies) that the school nurse should be aware of?

Medication Management

12. Does your child have a daily preventative medication taken at home for asthma? *

Mark only one oval.

Yes No

13. If you answered "YES" to the above question, what is the name of the medication:

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14. Does your child have a prescription for a rescue inhaler, such as Albuterol? *

Mark only one oval.

Yes No

15. Has your child been provided a spacer (i.e. aero-chamber) to use with their inhaler(s)? *



Mark only one oval.

Yes No

16. Will you be providing an inhaler to keep at school?

Mark only one oval.

Yes No

17. Will you be providing a spacer (e.g. aero-chamber) to keep at school? *

Mark only one oval.

Yes No

18. Is your child able to self-administer their medication? (Please contact the school nurse to complete a self-medication form if your child plans to self-carry their medication.)

Mark only one oval.

Yes No