SCHOOL ASTHMA HISTORY AND NEEDS ASSESSMENT

Student Name:________________________________ **Teacher/Team:**__________________________ **School Year** ____________

1. How long has your child had asthma?____
2. What signs and symptoms signal a flare up of your child's asthma?_______________________________________
____
3. Describe any special care your child requires at school. ____
____
4. Any dietary restrictions to follow at school?____
____
5. Describe the plan of care in the event of field trips, after-school activities and exercise. _________________________
____
6. How many days of school did your child miss last school year?
   ☐ 0 days ☐ 1-2 days ☐ 3-5 days ☐ 6-9 days ☐ 10-14 days ☐ 15 or more days
7. During the past year has your child's asthma ever stopped him/her from taking part in sports, recess, physical education or other school activities?
   ☐ None ☐ Some of the time ☐ All of the time
8. In the past month, during the day, how often has your child had a hard time with coughing, wheezing or breathing?
   ☐ 2 times a week or less ☐ More than 2 times a week ☐ All the time - throughout the day - every day
9. In the past month, during the night, how often does your child wake up or have a hard time with coughing, wheezing or breathing?
   ☐ 2 nights a month or less ☐ More than 2 nights a month ☐ More than 2 nights a week ☐ More than 4 nights a week

Equipment and Supplies Provided by Parents

_________ Daily Asthma Medications
_________ Emergency Asthma Medications
_________ Peak Flow Meter Supplies (with mouthpiece)
_________ Spacer for Metered Dose Inhaler Use
_________ Nebulizer Tubing/Mask

Please list asthma and allergy medications that your child takes at home:_______________________________________
____

I rate my child's need for additional knowledge about asthma as:

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my child's need to improve skills for self-management of asthma (use of inhalers, peak flow meters, symptom reporting) as:

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my child's health problems related to asthma currently as (Optional: See Asthma Control Test: D-6, D-7 of Missouri School Asthma Manual)

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my level of concern about asthma posing a safety risk for my child at school:

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate MY need for additional asthma information as:

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

Asthma Needs Score:* _________ *(sum of item scores)

Child's personal best peak flow number is ____
Green Zone (80-100% Personal Best) _______________Y ellow Zone (50-80% Personal Best)___________
Red Zone (Below 50% Personal Best) ____
Person Interviewed____ Date______________
Signature of School Nurse ____ Date______________