



**Florida Department of Health in Miami-Dade County
School Health Program
Health History and Consent: Asthma**

Student: _____ DOB _____ Teacher: _____ Grade: _____
 School: _____ Parent/Guardian & Phone(s): _____
 Physician & Phone: _____ School Year: _____
 KNOWN ALLERGIES: _____

Dear Parent/Guardian:

School records or medical information indicates your child has asthma. In order to attend to your child's health and safety, the school requires a health history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record. Our primary concern is that your child's healthcare needs are met while in school.

School Nurse

Phone number

Date

- When was your child diagnosed? _____ When was your child last asthma episode? _____
- Has your child ever been hospitalized for asthma? Yes__ No__, If yes, when _____
- What triggers your child's asthma episodes? (All boxes that apply)
 - Pollen Mold Dust Feathers Animal Dander Perfume Air pollution Smoke
 - Respiratory infections Cold air Weather changes Vigorous exercise
 - Foods (Specify) _____
 - Other _____
- What are your child's asthma symptoms? (all boxes that apply)
 - Coughing Wheezing Chest tightness Anxiety/Restlessness Difficulty breathing/shortness of breath Other (specify): _____
- Please list the medications your child takes for asthma:

Name of Medication	Dosage	Time

6. List any **other medications** your child takes:

Name of Medication	Dosage	Time

7. List any side effects your child experiences from his/her medication? _____

8. Does your child have any activity or dietary restrictions? Yes, No (Doctor's letter required if activity is limited)

9. Self-care: Does your child know:

How to identify asthma triggers (what causes asthma attack)?	Yes	No
The warning signs of asthma attack?	Yes	No
What medication to take?	Yes	No
To tell an adult if not feeling well	Yes	No

Consent:

Please circle your response and sign: **(I do /I do not)** give the school Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.

Parent/Guardian Signature: _____ Date: _____