



# Asthma Interview

SCHOOL YEAR \_\_\_\_\_

<b>Student</b>	Parent/Guardian	Phone
Date of Birth	Grade	
Pulmonologist	Parent/Guardian	Phone
Phone	Last visit	Emergency
Pertinent history including hospitalization.	<input type="checkbox"/> Maine Care	<input type="checkbox"/> Private Insurance
		<input type="checkbox"/> Need Information

After school activities	Age of onset	Last symptoms	Other medical conditions
<b>Known Triggers</b> <input type="checkbox"/> Illness <input type="checkbox"/> Smoke <input type="checkbox"/> Strong odors <input type="checkbox"/> Emotions <input type="checkbox"/> Physical activity		<b>Allergies:</b> <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Dust <input type="checkbox"/> Mold <input type="checkbox"/> Pollen <input type="checkbox"/> Food: Other:	

Answer the Following questions related to asthma.

In the past 12 months, how often has your child: _ ER/Urgent care visit _ Hospitalized _ Used oral steroids _ Missed school	In the past 4 weeks, how often has your child: _ Coughing, wheezing, trouble breathing _ Used a rescue inhaler _ Awakened at night due to asthma _ Had interruptions to normal activities
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Please be sure to list daily and emergency medications on the Annual Health Form.

Describe considerations necessary for the school day.

<input type="checkbox"/> Athletics/Physical Education	<input type="checkbox"/> Classroom
<input type="checkbox"/> Recess	<input type="checkbox"/> Bus/Transportation

Please share any health-related goals and needed assistance.

By signing below, I permit the school nurse to share information about my student's health with appropriate school and medical personnel for my student's ongoing safety at school.

Parent/Gaurdian \_\_\_\_\_ Date \_\_\_\_\_

*In an emergency when assistance is needed and emergency contacts are not reached, the healthcare provider will be contacted and if necessary 911 (emergency services) will be called.*