

**ASTHMA**

Has the child ever had Asthma?

*Alguna vez ha sufrido de asma?*

If the child has had asthma, please answer the following questions:

*Si ha sufrido de asma, conteste lo siguiente:*

- At what age did the child first have the first asthma attack?  
*A que edad tuvo el primer ataque?*
- How often does the child have asthma attacks?  
*Que frecuente tiene ataques de asma?*
- How many asthma attacks has the child had?  
*Cuantos ataques ha tenido?*
- When did the child have the last asthma attack?  
*Cuando tuvo el ultimo ataque?*
- Has the child been hospitalized for asthma?  
*Ha sido hospitalizado por asma?*
- When was the child last hospitalized for asthma?  
*Cuando fue hospitalizado por asma?*
- Has the child used asthma medicine in the past two years?  
*Ha usado medicamento para asma en los ultimos 2 anos?*

Yes/Si       No

Age: \_\_\_\_\_

Frequency: \_\_\_\_\_

How many? \_\_\_\_\_

Date: \_\_\_\_\_

Yes/Si       No

Date: \_\_\_\_\_

Yes/Si       No

**If the child needs asthma medication, the school nurse will require a written medication order from his/her doctor, so that we can care for him/her, if he/she has asthma attacks while at school. Si el estudiante necesita medicamento, la enfermera va a necesitar una orden medica por escrito del doctor, para poderle dar tratamiento si tuviera un episodio de asma en la escuela.**

Has the child ever been in the hospital for any other reason?

*Ha estado el estudiante en el hospital para alguna otra razon?*

Reason/*razon*: \_\_\_\_\_

Has the child ever had any broken bones?

*Se ha roto huesos el estudiante?*

Does the child have any allergies?

*Tiene el estudiante alguna alergia?*

Does the child have any other health problems?

*Tiene algun otro problema de salud?*

Yes/Si       No

How many days? *Cuantos dias?* \_\_\_\_\_

Year: \_\_\_\_\_

Yes/Si       No

If yes, please explain: \_\_\_\_\_

Yes/Si       No

If yes, please list what type(s): \_\_\_\_\_

Yes/Si       No

If yes, please list them: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of School Nurse Reviewing History: \_\_\_\_\_

Date: \_\_\_\_\_