Northern Michigan University
Asthma Information Form

Please complete the following information: Date ______________________

Name ______________________________________ Age __________ Grade _____________

Address ____

Telephone ____

Parent's/Guardian's Name(s) ____

Telephone (Home) ___________________________________(Work) _______________________

Emergency Contact ____

Relationship _______________________________ Telephone _____________________________

The following information is helpful to staff in determining any special needs your child has. Please answer the following questions to the best of your ability.

Doctor's Name _____________________________ Telephone _____________________________

1. How long has your child had asthma? ____

2. Please rate the severity of his/her asthma.

   (Not Severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

3. What triggers your child's asthma attack? (Check all that apply)

   ____ Illness ____ Emotions ____ Medications ____ Foods
   ____ Weather ____ Exercise ____ Smoke ____ Fatigue
   ____ Chemicals ____ Other ____

4. Please list any other helpful information regarding your child's asthma.

   ____
   ____
   ____

Thank you for providing this information. It will be given to the program staff to help meet your child's needs.

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