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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