



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

<b>Student Name:</b>	<b>Grade Level:</b>	
<b>DOB:</b>	<b>Age:</b>	
<b>Guardian #1:</b>	<b>Relationship:</b>	<b>Phone:</b>
<b>Guardian #2:</b>	<b>Relationship:</b>	<b>Phone:</b>
<b>Emergency Contact #1:</b>	<b>Relationship:</b>	<b>Phone:</b>
<b>Emergency Contact #2:</b>	<b>Relationship:</b>	<b>Phone:</b>
<b>Asthma Physician:</b>	<b>Physician Phone:</b>	

**Assessment Data** (Check if Applicable)

<b>Signs/Symptoms</b>	<b>Triggers</b>		<b>First Aid Interventions</b>
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Chalk/Markers	<input type="checkbox"/> Loosen Clothing
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Cold Air	<input type="checkbox"/> Perfumes	<input type="checkbox"/> Administer Medication
<input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Dust	<input type="checkbox"/> Smoke	<input type="checkbox"/> Encourage Relaxation
<input type="checkbox"/> Cough	<input type="checkbox"/> Stress	<input type="checkbox"/> Air Fresheners	<input type="checkbox"/> Encourage Pursed Lip Breathing
<input type="checkbox"/> Other:	<input type="checkbox"/> Infection	<input type="checkbox"/> Animals	<input type="checkbox"/> Administer Room Temperature Fluids
	<input type="checkbox"/> Allergies	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Frequency of Asthma Episodes:	Number of Hospitalizations in Past 12 Months:
-------------------------------	---

**Current Medications:** (Home/School/Both, including OTC and Alternative Meds)

<b>Medication Name</b>	<b>Home/School</b>		<b>Route</b>	<b>Dose</b>	<b>Frequency</b>
	<input type="checkbox"/> Home	<input type="checkbox"/> School			
	<input type="checkbox"/> Home	<input type="checkbox"/> School			
	<input type="checkbox"/> Home	<input type="checkbox"/> School			
	<input type="checkbox"/> Home	<input type="checkbox"/> School			
	<input type="checkbox"/> Home	<input type="checkbox"/> School			

Will student require nebulizer treatments at school? ☐ Yes ☐ No

**For Inhaled Medications:**

<input type="checkbox"/> I have instructed the student in the proper way to use his/her medications. It is my professional opinion that he/she <b>SHOULD NOT</b> be allowed to carry and use that medication by him/herself.
<input type="checkbox"/> It is my opinion that the student <b>SHOULD</b> carry his/her inhaled medication by him/herself. <b>MD SIGNATURE REQUIRED</b>
<div>1. Student knows action of the medication and reason for taking medication. 2. Student is aware of the possible side-effects of medication. 3. Student agrees to never share medication with anyone. 4. Student will always carry medication in correct container. 5. Student agrees to go to the nurse's office if symptoms are not relieved by medication or if student has to use the medication more than twice a day.</div>
If any of the above conditions are not met, student will forfeit the right to carry and self-administer medication.

<b>Physician Signature:</b>	<b>Signature Date:</b>
<b>Parent Signature:</b>	<b>Signature Date:</b>
<b>Student Signature:</b>	<b>Signature Date:</b>
<b>School Nurse Signature:</b>	<b>Signature Date:</b>