Centerville City Schools

ASTHMA INFORMATION FORM
FOR STUDENTS WITHOUT MEDICATION AT SCHOOL

Student Information

Student Name:	Birth Date:
Student Address:	Phone:
School:	Grade/Teacher:

If your child MAY require QUICK RELIEF medication at school, please complete ASTHMA MEDICATION AUTHORIZATION form. If your child currently does not require medication, complete this form. Please inform School Nurse if there are any changes in your child's asthma management.

Routine Home Asthma Medications

Medication Name	Dose	When Taken
1.______________________	__________	______________________
2.______________________	__________	______________________
3.______________________	__________	______________________

Personal Best Peak Flow (if known)____________________

What triggers your child's asthma attack?

__ Illness __ Exercise __ Smoke __ Strong odors/spray
__ Dust __ Pollen __Weather changes __ Ozone alert days
__ Mold __Stress __ Animals __ Extreme (hot/cold)
__ Strong emotions
__ Food ____

__ Other ____

Describe symptoms your child experiences before or during an asthma episode.

__ Cough, persistent __ Tightness or pain in chest __ Rubs/scratches chin/neck
__ Wheezing __ Irritability or agitation __ Complains of feeling tired/weak
__ Runny nose __ Shortness of breath or breathing hard/fast

__ Other ____

Emergency Plan – 911 will be called if your child has any of the following symptoms:

- Rapid labored breathing
- Pulling of skin of neck and chest with breathing and nasal flaring
- Can talk only in short, clipped sentences
- Blueness around mouth and nailbeds
- Change in mental status (becoming agitated, anxious, declining consciousness)
- Sweaty, clammy skin

Parent Name ______________________________ Date ____________________

Parent Signature ____________________________ Phone ____________________
(work/cell)