

Post Falls School District #273

School Nursing Services

206 W. Mullan Ave, Post Falls ID 83854

PO Box 40, Post Falls, ID 83877

(208) 773-6976



Asthma Information

Dear Parent/Guardian:

If your child has asthma please complete this form and return it to your child's school.

Student's Name: _____

School: _____ Grade: _____ Teacher: _____

Parent/Guardian: _____ Phone: _____

Physician's Name: _____ Phone: _____

1. How long has your child had asthma? _____

2. Please rate the severity of his/her asthma. (Circle one) Intermittent Mild Moderate Severe

3. How many times has your child been treated in the emergency room in the past? _____

4. What triggers your child's asthma?

- Illness Smoke Food Exercise Medications Fatigue
- Emotions Chemical odors Weather Allergies: _____

5. Please check what your student does at home to relieve an asthma attack:

- Breathing Exercises Rest/relaxation Drink liquids Inhaler Nebulizer
- Oral Medication Other: _____

6. Does your child need any special considerations related to his/her asthma at school such as modified gym class, no pets in the classroom and or avoid certain foods, field trips? Yes _____ No

7. Does your child take medication for asthma? Yes No Not currently

Please list all medications prescribed, supplements or over the counter:

Medications	Dose/Time	Side Effects:

If your child needs medication at school, please bring the medication to the school office in the original container (an extra prescription bottle may be prepared for school at the pharmacy).

An Authorization for Medication Administration form will need to be completed.

8. If your child needs an inhaler at school it is strongly encouraged to keep a rescue inhaler in the school office. Students should be able to tell an adult when they are having trouble with their asthma and know not share the inhaler.

- Inhaler to be kept in the office My child is aware of these expectations and will carry his/her own inhaler.
- Student will carry Emergency inhaler in: _____

9. If the school nurse has more questions regarding this form what is your preferred method of contact?

- Phone or Email: _____

Parent/Guardian's signature: _____ Date: _____

Thank you,
Elizabeth Costin, BSN, RN
Post Falls School District Lead Nurse

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