

*CHES Christian School*  
**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?**

- |  |                                   |  |   |
|--|-----------------------------------|--|---|
| <input type="checkbox"/> Illness         | <input type="checkbox"/> Exercise | <input type="checkbox"/> Smoke           | <input type="checkbox"/> Strong odors/spray |
| <input type="checkbox"/> Dust            | <input type="checkbox"/> Pollen   | <input type="checkbox"/> Weather changes | <input type="checkbox"/> Ozone alert days   |
| <input type="checkbox"/> Mold            | <input type="checkbox"/> Stress   | <input type="checkbox"/> Animals         | <input type="checkbox"/> Extreme (hot/cold) |
| <input type="checkbox"/> Strong emotions |                                   |  |   |
| <input type="checkbox"/> Food _____      |                                   |  |   |
| <input type="checkbox"/> Other _____     |                                   |  |   |

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Tightness or pain in chest                 | <input type="checkbox"/> Rubs/scratches chin/neck        |
| <input type="checkbox"/> Wheezing          | <input type="checkbox"/> Irritability or agitation                  | <input type="checkbox"/> Complains of feeling tired/weak |
| <input type="checkbox"/> Runny nose        | <input type="checkbox"/> Shortness of breath or breathing hard/fast |  |
| <input type="checkbox"/> 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)