Olton ISD
Asthma History Form

Student Name:____________________________ **DOB:**____________ **Grade:**_________

Homeroom Teacher:__________________

(1) **Emergency Contact Name/Number**:____

(2) **Emergency Contact Name/Number:**____

Physician Name/Number:____

Clinic Address:____

Last time student was seen by physician?____

When were you diagnosed with asthma?____

How severe is your asthma? (circle one) **Mild** **Moderate** **Severe**

What are your usual signs/symptoms during an asthma attack?

×wheezing ×cough ×difficulty breathing ×chest tightness ×anxiety ×other____________

What do you do at home to relieve the symptoms during an asthma attack?

×Rests ×drinks fluids ×breathing exercises ×checks peak flow ×takes medication

Other:____

What medications are you currently taking to control your asthma?

Medication Name	Dose	Frequency	Administer at school?

1. Are you knowledgeable about your medication? **Yes** **No**
2. Do you know when you need your medication? **Yes** **No**
3. Do you know how to properly use your inhaler? **Yes** **No**
4. Do you use a spacer? **Yes** **No**

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5. Does your child require medication at school? **Yes No**
6. Student may self-administer asthma medication at school? **Yes No**
7. Student may carry asthma medication on person while at school? **Yes No**

If yes to #5, the attached *Medication Authorization Form* must be completed and returned to the school nurse with the medication. The medication must be in the original labeled container. Inhalers must have a prescription label. The RN may also determine that an Emergency Action Plan needs to be completed in order to provide safe care of your child while at school.

If yes to #6 and #7, the attached *Self Administration Release Form for Inhalers* must be completed and returned to the school nurse. If your physician does not give permission for you to self-administer and carry your medication on your person while at school, ALL medication must be kept in the nurse's office.

Parent/Guardian Authorization

I consent that the above medication be administered during school hours as ordered by the student's physician. I request that medications be given on field trips or other school sponsored activities, as prescribed. I release school personnel from liability in the event adverse reactions result from taking the medication(s). I will notify the school of any change(s) in medication(s). I give permission for the school nurse to communicate with the student's teachers and physician about the student's asthma.

____________________	____________________	__________
Parent/Guardian Name	**Parent/Guardian Signature**	**Date**