Rusk Independent School District
203 E. 7th Street
Rusk, Texas 75785

RISD SCHOOL ASTHMA INFORMATION

STUDENT:_____ GRADE:_____ TEACHER:_____
DOB: _____ SCHOOL YEAR:_____ MEDICAL DIAGNOSIS: _____Asthma_____
Parent/Guardian Name:_____ Emergency Phone:_____
Physician Treating Asthma:_____ Phone:_____ Fax:_____
HOSPITAL PREFERENCE:_____

List the medications your child takes **daily** for asthma (please give amounts and time each is given):

_____

List the medications your child takes **as needed** for asthma (please give amounts and time each is given):

_____

Does your child need to take asthma medication **at school**? _____YES _____NO
If yes, a properly labeled prescription container and written permission from the parent and physician are required. What medication will be taken at school? _____

Does your child have consent from the physician to carry his/her inhaler with them at all times?___YES ___NO
If yes, please send consent to school.

Does your child have an **asthma action plan** from your physician? _____YES _____NO
If no, one will be sent home with your child for the physician to complete.

How old was your child when first diagnosed with asthma?_____

How often does your child have an asthma episode? _____

What is the first indication that your child's asthma is causing a problem? _____

What triggers your child's asthma symptoms?_____

When was the last time that an asthma episode caused you to take your child to the doctor?_____
To the emergency room? _____ To be hospitalized? _____

What side effects from medications have you observed in your child?_____

What helps your child other than medication if an asthma episode occurs?_____

_____

Does your child use a peak flow meter? _____YES _____NO What is the best reading? _____

Is there anything else you would like the school nurse to know about your child's asthma?_____

_____

_____ _____
Parent/Guardian Signature Date

PLEASE CONSIDER KEEPING AN INHALER AT SCHOOL FOR YOUR CHILD