Preschool ***Asthma*** or ***Reactive Airway Disease*** Assessment Form

Date: _____ Students Name: _____

Age: _____ Teacher: _____

Physician treating asthma/RAD: _____

Parent/Guardian: _____ Cell Number: _____

Parent/Guardian: _____ Cell Number: _____

Identify the thing(s) in which start an asthma episode for your child (please circle all that apply):

Exercise Respiratory Infections Change in temperature Grass

Animals Dust Strong odors/perfume Food: _____

Carpet Pollen Mold Other(s): _____

Date of last Asthma Attack: _____

Has your child ever been hospitalized for asthma? YES NO

How often does your child need a rescue inhaler/treatment? _____

Daily Medication Plan:

Medication Name: _____

Amount (puffs): _____ When: _____

As Needed Medication Plan:

Medication Name: _____

Amount (puffs): _____ When: _____

Medication Forms must be filled out for any medication needed while at school, along with a physicians order form

Emergency Medication Plan:

If student does not respond to above treatment within 15-20 minutes, then parent(s) will be contacted.

911 will be phoned if unable to reach a parent and/or child is experiencing a hard time breathing, constant coughing, gasping, trouble walking or talking, and/or lips start to turn blue.

Please see Parkview Preschool Parent Handbook for more information regarding breathing treatments.

Signature of Parent/Guardian: _____