Date: ______________________ Child's Name: _________________________________

Asthma / Reactive Airway Disease (RAD)

Has your child's medical provider ever told you that your child has either of the following? Asthma RAD

Severity Classification		Triggers		
Intermittent	Moderate persistent	Colds	Smoke	Weather
Mild Persistent	Severe Persistent	Exercise	Dust	Pollen
		Animals	Food	
		Other:		

Has your child ever been hospitalized or seen in the Emergency Room for breathing issues? Yes No

When? ____

Does your child have an asthma action plan? Yes No (**An Asthma Action Plan is Preferred**)

(Please attach asthma action plan if already established)

Does your child need their inhaler medication prior to strenuous exercise? Yes No

Please list all medications your child takes for Asthma or RAD. Indicate how much, how often and if medication is taken at home or school.

Medication: ex: Albuterol Dose: 2 puffs When: as needed Home School

Medication: _______________________ Dose: __________________ When: _______________ Home School

Medication: _______________________ Dose: __________________ When: _______________ Home School

Medication: _______________________ Dose: __________________ When: _______________ Home School

(Please use reverse as needed)

**** *MCCS Child development centers do not administer nebulized medication. Any inhaler brought to the center requires a spacer for administration of medication.*

_____________________________________ _______________________________________

Parent Signature Date Reviewed By Nurse Date