



School Health Program

Student Checklist: Asthma

Student Name: _____ **DOB:** _____

School Nurse: _____ **Date:** _____

The student has demonstrated understanding and competency consistently to:

SKILLS	YES	NO	COMMENTS
Identify asthma triggers			
Identify signs and symptoms of asthma episode or early distress			
State knowledge of medication: A. Correct name and expiration date B. Side effects C. Adverse reactions D. Appropriate use of medication per order E. Appropriate use of equipment/device (MDI, inhaler, flow meter and nebulizer)			
Understands the importance to alert staff of poor response to self-administered medication			
State the need to call 9-1-1			

The student agrees to follow the safety precautions with medication compliancy and report any signs distress.

Student Signature _____ Date: _____

Parent Name/Signature _____ Date _____

I hereby acknowledge that the student listed above has demonstrated all the above listed skills.

School Nurse Signature _____ Date _____

Review Dates: _____