Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click Print button.

Illinois State Board of Education

100 North First Street
Springfield, Illinois 62777-0001

UNDESIGNATED ASTHMA MEDICATION REPORTING FORM

WELLNESS DEPARTMENT

Directions: This form must be completed within three (3) calendar days after the administration of any undesignated quick relief asthma medication in accordance with Public Act 100-0726. All completed forms must be submitted via online collection portal webpage.

DISTRICT NAME AND NUMBER	RCDT CODE [Click Here to Find Code]	NAME OF SCHOOL

ADDRESS (Street, City, State, ZIP Code)	CONTACT PERSON COMPLETING FORM
TELEPHONE (Include Area Code)	CONTACT EMAIL
DATE OF INCIDENT	TIME OF INCIDENT _____ a.m. _____ p.m.

1. Age of individual receiving quick relief asthma medication: _____
2. Description of person receiving the medication: ***(Check one only)***
   - ☐ a. Student
   - ☐ b. Staff member
   - ☐ c. Visitor
   - ☐ d. Other (please specify) _____
3. Was there any previously known diagnosis of asthma?
   - ☐ a. Yes (If Yes, did the student have an Asthma Action Plan? ☐ Yes ☐ No
   - ☐ b. No
4. What experience occurred that lead up to symptoms developing?
   - ☐ a. Known exposure to allergen
     - Type of allergen
       - ☐ i. Pollen
       - ☐ ii. Dust
       - ☐ iii. Animal dander
       - ☐ iv. Other
         - Specify _____
   - ☐ b. Environmental exposure
     - Type of exposure
       - ☐ i. Smoke
       - ☐ ii. Air pollution
       - ☐ iii. Weather extremes (heat/cold)
   - ☐ c. Exercise induced
   - ☐ d. Unknown
   - ☐ e. Other
     - Specify _____
5. Symptoms of respiratory distress that were noted: ***(Check all that apply)***
   - ☐ a. Presence of wheezing (actual or perceived)
   - ☐ b. Coughing
   - ☐ c. Shortness of breath (actual or perceived)
   - ☐ d. Chest tightness (actual or perceived)
   - ☐ e. Breathing difficulty
   - ☐ f. Other symptoms consistent with asthma. (please specify) _____
6. Location of where symptoms developed: ***(Check one only)***
   - ☐ a. Within school building
   - ☐ b. On school grounds
   - ☐ c. Other (e.g., school activity location, field trip location, etc.) _____

7. Name or drug administered

- ☐ a. Albuterol via multi dose inhaler (MDI)
- ☐ b. Albuterol via nebulizer
- ☐ c. Other (please specify drug and route) _____

8. Type of person administering the medication: ***(Check one only)***

- ☐ a. Registered Nurse
- ☐ b. Other nurse (LPN, APRN)
- ☐ c. Trained Personnel (as described in P.A. 100-0726)
- ☐ d. Other (please specify) _____

9. Disposition of person to whom asthma medication was administered:

- a. Returned to class/role or class/responsibilities after _____(number of minutes)
- b. Monitored by trained personnel _____(number of minutes) then picked up by parent/guardian or friend/family member.
- c. Monitored by trained personnel _____(number of minutes) then transported by EMS.
- d. Monitored by trained personnel _____(number of minutes) returned to class/role or class/responsibilities.

10. If student, was the student's health care provider notified?

- ☐ Yes
- ☐ No ☐ Parents Refused

11. If student, and nurse was not in attendance, was the school nurse notified?

- ☐ Yes ☐ Nurse attended
- ☐ No ☐ District has no nurse

Comments ***(Please contain your response into the space provided)***:

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