"We Inspire and Empower Learners"

SCHOOL ASTHMA RECORD

(To be completed by Parent/Guardian)

Child's Name _____ Date _____

Parent/Guardians(s) Name _____

Address _____ Home Phone _____

City _____ Alternate Phone _____

Physician Treating Child's Asthma _____

Physician's Phone _____

1. When was your child diagnosed with asthma?

2. Has your child ever been hospitalized for an asthma-related illness? If yes, when?

3. Approximately how often does your child have a severe acute asthma episode?

4. Briefly describe what triggers your child's asthma symptoms. Allergens? Exercise?

5. Are there any sports that are restricted from your child's plan of care? If yes, list.

6. Do certain weather conditions affect your child's asthma? If yes, please list.

7. List all medications that your child takes routinely including dosages, frequency, & side effects.

8. Does your child understand asthma and what to do to manage it?

9. How do you want the school to treat an episode of asthma if it should occur?

10. If the child does not respond to the treatment at school, what action should the school take?

Parent/Guardian Signature _____ Date _____