SCHOOL ASTHMA RECORD

Child's Name_____ Date_____

Parent's Name_____ Phone(home)_____

Address_____ Phone(work)_____

Physician Treating Child's Asthma_____ Phone#_____

1. Briefly describe what causes your child's asthma symptoms:_____

_____

2. Does he or she do breathing exercises that are helpful in managing asthma? _____

3. In which sports can the child fully participate?_____

4. Does exercise induce episodes of asthma? If so, list types of exercise._____

_____

5. Do certain weather conditions affect your child's asthma? If so, list them._____

_____

6. Name the medication taken routinely, the dose, how often taken, when, and under what circumstances additional doses should be given_____

_____

7. Does your child experience any side effects to these medications? If so list_____

_____

8. Does your child understand asthma and what he or she should do to manage it?_____

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

_____

10. Approximately how often does the child have an acute episode?_____

11. If the child does not respond to medication, what action do you advise school personnel to take? _____

_____

12. Does your child need an inhaler for school? No_____ Yes _____ *If yes, please send in the inhaler with the asthma treatment plan signed by parent and physician.*

Comments: _____

_____

Parent/Guardian Signature