ASTHMA INFORMATION

Student: Name _____ Grade_____

School_____ Teacher_____

Parent: Name _____Phone_____ Work Phone_____

Emergency Contact and Phone #_____

Physician's Name and Phone_____

List known allergies:_____

How would you rate the severity of your child's asthma?

(Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

What triggers your child's asthma/wheezing?

____Illness ____Molds ____Fatigue Other_____
____Changes in temperatures ____Sprays/odors ____Animals
_____
____Foods ____Stress/emotion ____Pollens
____Chalk dust ____Exercise ____Dust

What does your child do to relieve wheezing/asthma symptoms?

____Breathing exercises _____Drinks liquids Other_____
____Rest/relaxation _____ Medications (list below)
_____

Please list the medications your child takes for asthma and /or allergies (everyday and as needed).

Name of Medication	Dose	Frequency

Will your child require medication/inhaler during school hours?

_____Yes* _____No

***If Yes, a school medication form must be obtained & completed by the physician & parent.**

Does your child know how to use his/her inhaler/spacer? Yes_____ No_____

Does your child require any special considerations related to his/her asthma while at school?

___ Modified gym class ____No Animals in classroom ____Behavior/emotional concerns
___ Modified recess ____Avoidance of certain foods ____ Other_____

_____

Signature of Parent/Guardian Completing form Date