SCHOOL ASTHMA RECORD

Child's Name: _____ Grade: _____

Parent's Name: _____ Telephone (Home): _____

Address: _____ Telephone (Work) _____

Physician Treating Child's Asthma: _____ Telephone: _____

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

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

3. In which sports can the child fully participate?

4. Does exercise cause 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 medications taken routinely, the dose, how often taken, when, and under what conditions should additional doses be given. Will medication need to be given at school?

7. Does your child suffer any side effects to these medication? (If so, list them.)

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. How often does your child have an acute episode?

11. If the child does not respond to medication, what action does the parent advise school staff to take?

COMMENTS:

_____ _____

Date Signature of Parent or Guardian