Dear Parent/Guardian: Thank you for providing this information to us to help keep your child safe and healthy at school. Your school nurse will be in contact with you if follow up information is needed. Please return all forms to your child’s school office or email them to hservices@mesd.k12.or.us

Child’s Name:       Date of Birth       Today’s Date

School:

Parent/Guardian(s):

Health Care Provider:       Phone       Fax

**History:**

When was your child diagnosed with asthma?

When was your child’s last asthma “attack”?

Do any of these things cause your child’s asthma to get worse?  Exercise  Stress  Lung Infections  Exposure to cold air  Allergies  Other

In the last year, has your child needed to go to the emergency room for asthma?  Yes  No

If yes, when?

Can your child take part in all school activities (PE, recess, etc.)? Yes  No

If no, please explain what restrictions of activities there are for your child?

**Treatment:** For students in grades K-5, or students requiring extra help, medications/equipment should be kept in the health room or other agreed upon, secure location. **All medications at school must be kept in their original containers. Prescription medications must have pharmacy labels attached.**

Below, please indicate the medications your child uses to control/treat their asthma.

Daily scheduled inhaler: Medication name, dose & how often

Rescue Inhaler: Medication name, dose & how often

Nebulizer: Medication name & how often

My child does not take medication for their asthma.

What medication(s) will be needed at school?

Equipment needed at school:  Peak Flow Meter  Spacer  Other

Will your child have the above medication(s) or equipment stored in the health room?  Yes  No

Other intervention(s) used to control/treat your child’s asthma: