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: