Dear Parent/Guardian: Thank you for providing this information to us to help keep your student safe and healthy at school. Your school nurse will be in contact with you if follow up information is needed.

Student Name:       Date of Birth       Today’s Date

School:

Parent(s)/Guardian(s) name(s):

Health Care Provider:       Phone:       Fax:

**History:**

When was your student diagnosed with asthma?

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

Do any of these things cause your student’s asthma to get worse? [ ]  Exercise [ ]  Stress [ ]  Lung

Infections [ ]  Exposure to cold air [ ]  Allergies [ ]  Other

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

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

**Treatment:**

How is your student’s asthma treated/controlled?

[ ]  Daily scheduled inhaler: Medication name & how often

[ ]  Rescue Inhaler: Medication name & how often

[ ]  Nebulizer: Medication name & how often

What medication(s) will be needed at school?

Equipment needed at school: [ ]  Peak Flow Meter [ ]  Spacer ☐Other

For students in grades K-5, or student’s requiring extra help, medications/equipment should be kept in the health room.

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

Based on your students' health conditions please complete additional forms if you have not already.

Please return all forms to your student’s school office.

**Note: All medications at school must be kept in their original containers. Prescription medications must have pharmacy labels attached. Medication form must be completed.**