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MARPLE NEWTOWN SCHOOL DISTRICT
NEWTOWN SQUARE, PENNSYLVANIA 19073
HEALTH SERVICES DIVISION

School Asthma Record

Date_____

Dear Parent/Guardian:

You have told us that your child has asthma.

Please fill out the asthma record form on the back and return it to the School Nurse. The information will be shared with school personnel such as your child's classroom teacher(s) and physical education teacher on a need to know basis. The information will help them work with your child to minimize unnecessary restriction of activity and feeling of being treated differently.

Please let the nurse know of changes in your child's asthma management or medication schedule so we can help to keep your child healthy.

Thank you for your cooperation,

_____
School Nurse

_____
Telephone

Asthma Questionnaire

***Child's Name*_____ *Grade*_____ *Teacher*_____**
***Parent's Phone (home)*_____ *(cell)*_____**
***(work)* _____**

***Physician treating child's asthma*_____ *Phone*_____**

1. How long has your child had asthma?_____

2. When was your child last seen by a doctor for their asthma?_____

3. Please rate the severity of your child's asthma (circle one)

NOT SEVERE 1 2 3 4 5 6 7 8 9 10 SEVERE

4. Has your child ever gone to the hospital for an asthma attack? _____

5. What triggers an asthma attack? (circle all that apply)

Illness Emotions Medications Foods Weather Exercises

Fatigue Odors Cigarette Smoke Other_____

6. Please describe your child's asthma attack (symptoms/duration)

_____
_____

7. How do you treat an attack at home? (circle all that apply)

Breathing Exercise Rest/Relaxation Drink Liquids

Medications: Inhaler Nebulizer Treatment Oral Medication

8. Please list medications your child takes every day for asthma:

Name of Medication_____ Frequency _____

Name of Medication_____ Frequency _____

*****Please Return to the Nurse's Office as soon as possible*****

Signature of Parent/Guardian_____ Date _____