MARPLE NEWTOWN SCHOOL DISTRICT

School Asthma Record

School Year: 2023-24

Date: _____

Dear Parent/Guardian:

You have indicated that your child has asthma.

Please complete the asthma record form and return it to the School Nurse. The information is helpful to the school nurse and staff in determining any special needs for your child due to asthma. Please answer the questions to the best of your ability. The information will be shared with school personnel on a need to know basis (classroom teacher(s), physical education teacher, etc.).

Please let your school 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.

Sincerely,

_____

School Nurse

MARPLE NEWTOWN SCHOOL DISTRICT

Student's Name: _____ Grade: _____

Teacher: _____ Homeroom# _____

Parent's Name: _____ Cell Phone: _____

Physician's Name: _____ Phone: _____

1. How long has your child had asthma? _____

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

3. Rate the severity of his/her asthma. _____ (*Not Severe*) 0 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 your child's asthma attacks? (*Please check all that apply*.)

☐ Illness ☐ Emotions ☐ Medications ☐ Foods

☐ Weather ☐ Exercise ☐ Cigarette or other smoke ☐ Chemical odors

☐ Allergies *(please list)* _____ ☐ Fatigue

☐ Other *(please list)* _____

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

_____

_____

7. : How do you treat an asthma attack at home? *(Please check all that apply.)*

☐ Breathing exercises

☐ Rest/relaxation

☐ Drinks liquids

Takes Medication:

☐ Inhaler

☐ Nebulizer

☐ Oral medication

Other (*please describe)* _____

_____

8. What medications does your child take and how often?

Name of Medication: _____Frequency: _____

(Daily – Before Exercise – Wheezing/Attacks - Other.)

Name of Medication: _____Frequency: _____

(Daily – Before Exercise – Wheezing/Attacks - Other.)

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(Daily – Before Exercise – Wheezing/Attacks - Other.)

Please return to the School Nurses Office as soon as possible

Parent / Guardian Signature _____

Date _____