Asthma

Date:__________

*Please fill out this form and turn it in to your student's secretary. A new form must be completed every school year!

Student Name:____ DOB:_______________________

School:____ Teacher:_________________________

What are your student's Asthma Symptoms (Please check which apply.) Wheezing: ☐ Coughing: ☐ Shortness of Breath: ☐ Other: _________________ ☐ Chest Tightness/Pain: ☐ Low peak expiratory flow (PEF) readings: ☐
What are your student's Asthma Triggers? (Please check which apply.) Cold Air: ☐ Exercise/Sports: ☐ Environmental Allergies: ☐ Seasonal Allergies: ☐ Other: __________ ☐
Does your student have an inhaler? (If yes, please list the type below.) Yes: ☐ No: ☐
Where is your student's inhaler located? Home: ☐ Office: ☐ Student's Locker: ☐ With Student: ☐
If your student's inhaler is at school, there must be a form on file in the office for your student. Do we have this form on file? Yes: ☐ No: ☐
Does your student take any other medications to help control their Asthma? (If yes, please list which below.) Yes: ☐ No: ☐
Does the school have an Action Plan from the doctor for your student? Yes: ☐ No: ☐

Additional Comments: ____
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Parent/Guardian Name (printed): ____

Signature:____