Pennsauken Public Schools
Special Services Department

School Asthma Record

Dear Parent:

You have told us that your child has asthma. Please complete the questionnaire below. I will share the information with the appropriate personnel such as the child's classroom teacher (s) and physical education teacher.

Also, please notify me of any changes in your child's asthma and/or medication schedules. Thank you.

Student Name:_____ Date:_____

Physician Treating Asthma:_____ Phone:_____

1. Check when the child's asthma symptoms are likely to occur:

O Winter **O Spring** **O Fall** **O Year Round**

2. Check how often the child's asthma episodes occur:

O Frequently **O Occasionally** **O Rarely**

3. Check which of the following are the child's triggers:

O Exercise	**O Colds / other infections**	
O Change in weather/temp.	**O Chalk dust**	**O Emotions/Stress**
O Breathing cold air	**O Pollens (weeds, grass, trees)**	**O Smoke**
O Pets	**O Molds**	**O Other:_____**
O Strong Odor/Perfume	**O Dust**	**O Food:_____**

4. Check the child's asthma symptoms:

O Cough	**O Rapid breathing**	**O Wheeze**
O Irritability	**O Shortness of breath**	**O Chest Tightness**
		O Other_____

5. List any medication prescribed for asthma and/or allergy symptoms:

	Medication Name	**Dosage**	**How Often**
O Inhaler	_____	_____	_____
O Nebulizer	_____	_____	_____
O Oral Medication	_____	_____	_____
OAllergy Medication	_____	_____	_____

6. Will your child require any medication during school hours? _____

_____ _____

Parent Signature **Date**