Department of Special Services

Name: ___________________ School: ________________ Grade _______ Date: ________

ASTHMA MEDICAL INFORMATION

Dear Parent(s)/Guardian(s)

You have informed me that your child has asthma. In order to provide a comfortable and secure environment for your child, I need to have the following information. Please call me at any time to discuss your child's treatment and medication(s).

____
School Nurse

Physician____ Phone___________________

I. Symptoms for which medication is prescribed: ______________________________
____

II. Medication Dosage Time/Circumstances Side Effects Side Effects

1.____
____

2.____
____

3.____
____

III. Describe causes of an episode (weather, allergies, illness, exercise, other):
____
____

IV. How often does an episode occur? ______________________________________

V. Last episode? ____

VI. Does your child use a Peak Flow Meter? YES________NO________

If YES what is the normal baseline reading? ______________________________

VII. If your child does not respond to treatment, what action should be taken? _________
____

VIII. Comment____

__________________________ ____
Signature of Parent/Guardian Telephone Cell

Date received by nurse__________________________

RG (N12-**Asthma Medical Information**) 2014