School Asthma Record

Child's Name _____ Date _____
Parent(s) Name _____ Home Phone _____
Address _____ Work Phone _____
City/State/Zip _____
Physician Treating Asthma _____
Physician's Phone _____

1. Briefly describe what causes child's Asthma symptom:

2. Does he or she do breathing exercises that are helpful in managing the asthma?

3. In which sports can the child fully participate?

4. Does exercise induce episodes of asthma? (If so. list which types of exercise).

5. Do certain weather conditions affect your child's asthma? (If so, list them).

6. Does your child understand asthma and what to do to manage it?

7. How do you want the school to treat an episode of Asthma should it occur?

8. Approximately how often does your child have an acute episode?

9. If the child does not respond to medication, what action does the parent/guardian Advise school personnel to take?

Comments: _____

Parent Signature: _____