ASTHMA WORKSHEET

STUDENT NAME:_____ GRADE: _____

PARENT/GUARDIAN NAMES: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ ALTERNATE: _____

PHYSICIAN NAME: _____ PHONE: _____

In the event of an emergency at school, please list your hospital preference:

_____ CLINTON _____ HARRISONVILLE (EMS will have the final decision)

MARK THE TRIGGERS WHICH CAUSE ASTHMA ATTACKS FOR YOUR CHILD:

____Respiratory infections	____Pollens	____Chalk dust	____Virus
____Change of temperature	____Molds	____Allergies _____	
____Strong odors of fumes	____Exercise	____Food _____	
____Carpets in the room	____Animals	____Other _____	

MARK THE SIGNS & SYMPTOMS OF ASTHMA ATTACKS FOR YOUR CHILD:

____Coughing (especially at night and during exercise)
____Wheezing (musical whistling sound)
____Difficulty breathing
____Retractions (skin of chest and neck pulled in)
____Feeling of tightness in chest
____Other _____

WHAT STEPS DOES YOUR PHYSICIAN RECOMMEND IN THE EVENT OF AN ASTHMA ATTACK?

_____

_____

EMERGENCY CONTACTS WE MAY ACCESS IS UNABLE TO REACH YOU? (NAME & NUMBER)

_____

_____

If you have an asthma action plan for your child, please attach a copy. If your child does not have an asthma action plan, please have your physician complete one and send it to us as soon as possible. We want to be prepared in the event your child has an asthma attack at school. Please sign below for permission to share this information with staff on a need to know basis.

PARENT/GUARDIAN _____ DATE: _____