STUDENT ASTHMA INFORMATION SHEET

(To be filled out by parent/guardian)

Student Name _____ Grade _____ Teacher _____

Describe the type of symptoms your child experiences (e.g. wheezing, coughing, tightness, other)

_____

What usually helps if an attack occurs?

_____

Medications child takes: (name, dose, frequency)

_____

_____

Side effects of medication that your child experiences:

_____

Does your child use a peak flow meter? Yes / No (please circle one)

If yes, what is the current peak flow? _____

Additional information/instructions:

_____

_____

_____

Number of times the child has been taken to an emergency facility for an acute attack of asthma in the past 12 months _____

Details, if you wish to disclose:

_____

Please contact the school nurse if information or child's condition changes during the school year.

Thank you for your assistance in providing the best care for your child.

Kari Leal, RN
Great Hearts Live Oak School Nurse