



STUDENT SERVICES

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3766

ASTHMA

(Student Name)	(School)	(Fax No.)	(Birthdate)	(Grade)
(Physician's Name)			(Phone)	

Dear Parent:

Your child's Emergency Care Card indicates that your child has **asthma**. Please provide the following information:

Date or age of diagnosis: \_\_\_\_\_ Approximately how often does your child have an acute episode? \_\_\_\_\_  
 When was the last asthma attack? \_\_\_\_\_

Briefly describe what causes your child's asthma symptoms: \_\_\_\_\_

Are there physical education restrictions? Yes  No

Do you have a doctor's written excuse? Yes  No

Does exercise induce episodes of asthma? Yes  No  (If yes, list types of exercises.) \_\_\_\_\_

Conditions/symptoms which warrant medication: \_\_\_\_\_

If more than one is given, which should be taken first? \_\_\_\_\_

Names of medications taken routinely:

a. Name of medication: _____	Name of medication: _____
Dosage: _____	Dosage: _____
How often: _____	How often: _____
When: _____	When: _____

b. Should medication be kept at school? Yes  No

If your answer is yes, please pick up Physician's and Parent's authorization forms and bring medication with the doctor's written request to the Health Office. Return forms with medication in the pharmacy bottle. Both authorization forms are required even if your child self-medicates.

Does your child suffer any side effects to these medications?  Yes  No

If your answer is yes, please list: \_\_\_\_\_

c. If asthma is so severe as to warrant the student carrying the inhaler (middle and high school only), please check.  
 Yes  No If your response is yes, pick up additional forms at the school office.

Does your child understand asthma and what he/she should do to manage it?  Yes  No

Please list the appropriate responses in a specified order that the school should take if an episode of asthma should occur (the steps your child routinely takes when he/she experiences an asthma attack): \_\_\_\_\_

**(Parent/Guardian Signature)**

**(Date)**