Hamilton-Wenham Regional School District

Dear Parent or Guardian,

You have informed us that your child has asthma. Please carefully complete and return this asthma record to school immediately so your instructions may be shared with appropriate school personnel. This information will allow us to work with your child to minimize unnecessary restriction, the feeling of being treated differently, and possible absenteeism. Please be sure to let us know immediately of any changes in your child's asthma or medication. Thank you.

INDIVIDUAL STUDENT ASTHMA RECORD

Child's name: _____ Date: _____
School: _____ Grade / Teacher: _____
Parent's Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
Doctor's Name: _____ Doctor's Phone: _____

1. Briefly describe what causes your child's asthma symptoms:

2. Can your child fully participate in physical education and sports? _____

3. Does exercise induce episodes of asthma? _____ If so, list the exercises that have done this.

4. Do certain weather conditions affect your child's asthma? _____ If so, please list.

5. Please list all asthma medications your child takes regularly: (Include name of medication, the dosage and how often taken.)

_____
_____
_____

6. Please list any asthma medication your child will need to take during school hours. (Your child's doctor must complete a permission form for each medication.)

7. Does your child have side effects from any of these medications? Is so, please list.

8. Does your child understand asthma and what he or she should do to manage it? _____

9. Approximately how often does your child have an acute asthma episode (attack)? _____

10. Please outline what you would like the school to do if your child has an asthma episode. BE SPECIFIC.

11. If your child does not respond to medication, what action do you advise school personnel to take?

Parent Signature: _____ Date: _____

5/02