STUDENT ASTHMA INFO SHEET

Student name_____
Homeroom_____

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

What usually helps if an attack occurs?

Medications child takes:
Name
Dosage
Frequency

Name
Dosage
Frequency

Side effects of medication that your child experiences:

Additional information/instructions:

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

Thank you,
Suzanne Krejci, LVN
School Nurse

CONTRACT BETWEEN STUDENT, PARENT, and NURSE/SCHOOL

for permission to carry inhalers.

1. Student has a history of asthma.
2. Student has demonstrated to the nurse correct use of inhaler.
3. Student agrees to never share the inhaler with another person.
4. Student agrees that after two puffs, if there is not marked improvement, he/she will go to see the school nurse immediately.

_____
Student Signature

I give permission for my child_____, to carry the inhaler described below. I understand that he/she must follow the rules listed above. I will notify the school of changes in medication or my child's condition.

Name of Medication	Dose	Frequency to use
_____	_____	_____
_____	_____	_____

_____ _____
Parent's signature Date

I verify that _____has a diagnosis/history of asthma. As a result, I have prescribed the following inhaler to be used. He/she has demonstrated the capability of self-administering the medication.

Name of medication_____
Dosage_____
Times or circumstances medicine may be used_____
Beginning date may be used_____Ending date_____

_____ _____
Signature of Physician/PA/ NP Date

_____
Print Name of Physician/PA/ NP