

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

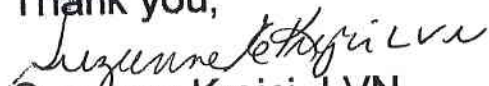
Frequency

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