

Asthma Management Sheet

Student's name: _____ Grade: _____ Teacher: _____

Parent/Guardian's name: _____ Phone: _____

Name of doctor treating asthma: _____ Phone: _____

Name of local pediatrician: _____ Phone: _____

My child was diagnosed with asthma when he/she was _____ years of age. Triggers/allergies for my child are _____

My child knows how to properly use inhaler? Yes _____ No _____

My child uses a spacer? Yes _____ No _____

My child's peak flow when healthy is _____. My child currently is taking the following medication(s) and dose(s): _____

My child should take his/her _____ medication _____ minutes prior to gym class? Yes _____ No _____

My child has an asthma care contract set up with his/her doctor for expectations as to what he/she needs to do to keep asthma in control.? Yes _____ No _____

My child has a good working knowledge about his/her asthma? Yes _____ No _____

Please keep my child's teacher updated on his/her asthma care. I also give the nurse permission to speak with his/her doctor as needed along with parent notification.

Parent/Guardian's signature _____ Date _____