

LINDEN PUBLIC SCHOOLS  
DEPARTMENT OF MEDICAL INSPECTION  
ACADEMY OF SCIENCE & TECHNOLOGY  
128 WEST ST. GEORGES AVENUE  
LINDEN, NEW JERSEY 07036

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**SCHOOL ASTHMA RECORD**

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent's Name \_\_\_\_\_ Phone (home) \_\_\_\_\_

Address \_\_\_\_\_ Phone (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Physician Treating Child's Asthma \_\_\_\_\_ Phone \_\_\_\_\_

1. Briefly describe what causes the child's asthma symptoms: \_\_\_\_\_
2. Does he or she do breathing exercises that are helpful in managing the asthma? \_\_\_\_\_
3. In which sports can the child fully participate? \_\_\_\_\_
4. Does exercise induce episodes of asthma? (If so, list types of exercise.) \_\_\_\_\_
5. Do certain weather conditions affect your child's asthma? (If so, list them.) \_\_\_\_\_
6. Name the medications taken routinely, the dose, how often taken, when, and under what circumstances additional doses should be given. \_\_\_\_\_
7. Does your child suffer any side effects to these medications? (If so, list.) \_\_\_\_\_
8. Does your child understand asthma and what he or she should do to manage it? \_\_\_\_\_
9. How do you want the school to treat an episode of asthma if it should occur? \_\_\_\_\_
10. Approximately how often does the child have an acute episode? \_\_\_\_\_
11. If the child does not respond to medication, what action does the parent/guardian advise school personnel to take? \_\_\_\_\_

COMMENTS:

\_\_\_\_\_  
Parent/Guardian Signature