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