ANNUAL ASTHMA UPDATE

Name: ____ **Grade:** _______________

School: ____

**** The following information is to be completed and signed by the parents and physician at the beginning of each school year.**

Medical Condition: Asthma

Frequency of Attacks: o 1-10 times weekly o 1-10 time monthly o rarely
o No problems since (Year) __________

Causes of Asthma Attacks: o Allergens o Exercise o Weather o Unknown

Use of Medication: Type ____
Frequency ____

Does your child use a peak flow meter? o Yes o No Range ___________________

**** If your child requires oral medication or an inhaler in school this medication must be brought to the school clinic and a medication permission slip signed by the parent or guardian.**

Release of Information

Dr. _______________________,
I hereby authorize the release of medical information regarding asthma for my son/daughter __________________________, date of birth ___________________. It is my understanding that such information is to be kept confidential and will be used to assist the school in making the necessary health care provisions during the school day.
Parent signature: _____________________________________ Date: _________________

Current Medical Dx: ____

Current Medications: ____

Student may carry inhaler: o Yes o No * Not recommended for students under grade 6

Activity Restrictions: ____

Physician Signature: _________________________________ Date: ___________________