LINDEN PUBLIC SCHOOLS
DEPARTMENT OF MEDICAL INSPECTION
ACADEMY OF SCIENCE & TECHNOLOGY
128 W. ST. GEORGES AVE., LINDEN, NJ 07036

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Superintendent of Schools

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SCHOOL ASTHMA RECORD

Child's Name _____ Date _____

Parent's Name _____Phone (home) _____

Address _____Phone (work) _____

Phone (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 medication taken routinely, the dose, how often taken, when and under what circumstances additional doses should be given. _____
7. Does your child suffer and 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 has an acute episode? _____
11. If the child does not respond to medication, what action does the parent/guardian advise the school personnel to take? _____

COMMENTS:

_____
Parent/Guardian Signature