Parent/Guardian Questionnaire for Students with Asthma
Coatesville Area School District

In order to give the appropriate care, we request that you complete this form and return it to the School Nurse. Please notify the School Nurse <u>in writing</u> if there are any changes in this information during the school year

Student Name: _____ School: _____

School Year: _____ Grade: _____ Homeroom/Advisory: _____

Symptoms student has experienced in the past (please check all that apply)

_____Coughing _____Wheezing

_____Hoarseness _____Breathing difficulty

_____Dizziness _____Thickened speech

_____Extreme weakness _____Blue color of skin or lips

_____Abdominal cramps _____Other _____

Type of Asthma: _____Exercise Induced _____Allergic _____Viral

Medications needed:

Name:_____Dose/Frequency:_____

Name:_____Dose/Frequency:_____

Special Instructions:_____

Can student use and Inhaler (if needed) without help? _____ YES _____ NO

PLEASE REFER TO MEDICATION POLICY/PERMISSION FORM IF MEDICINE IS NEEDED AT SCHOOL

Name of Physician _____Phone Number_____

I understand the above information will be used in an emergency action plan for my child. I give my permission to share this plan with my child's assigned teachers and appropriate personnel.

Signature of
Parent/Guardian_____Date_____