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: _____