ASTHMA ALERT

STUDENT'S NAME: _____SCHOOL YEAR: _____
GRADE: _____TEACHER:_____
ADDRESS:_____ BUS#_____

My child has **ASTHMA**. Although children with **ASTHMA** rarely need emergency care, there are concerns and considerations of which I would like to make you aware. Should my child experience difficulty with his/her **ASTHMA,** I would like for you to know what to expect.

MEDICATIONS/INHALERS	**DOSAGE**	**SIDE EFFECTS**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

SYMPTOMS EXPERIENCED

1. _____
2. _____

ALLERGENS/IRRITANTS (that bother my child)

1. _____

SPECIFIC INSTRUCTIONS (if my child has an asthma flare up)

1. _____
2. _____

****PARENT OR GUARDIAN:** Please complete this **ASTHMA ALERT** sheet to return it to the Nurse's, Principal's, teacher and designated staff to use in caring for your child. Each inhaler and medication needs the student's name and RX information attached. Each student keeps the inhaler with him/her in a pocket, in the student's desk or in the student's backpack while riding the school bus.

TWO WRITTEN PERMISSIONS ARE REQUIRED AS OF JULY 1, 2001

****YOUR DOCTOR'S WRITTEN PERMISSION IS REQUIRED** for all Asthma medications "kept by your student in school". This may be accomplished by FAX or written script from your doctor's office which is sent to the Principal's Office of your student's school.

SIGNED: _____PHONE #:_____DATE:_____
CALL 1ST: NAME & WORK PHONE _____
CALL 2ND: NAME & WORK PHONE _____

BY SIGNING THIS FORM, I AGREE TO AL LOW THIS INFORMATION TO BE SHARED WITH ANY AND ALL SCHOOL PERSONNEL WHO MAY BE IN CONTACT WITH MY CHILD. *Updated 4/17*