

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

Student Name _____ School _____

School Year _____ Grade _____ Date _____

Dear Parent/Guardian,

You noted on the emergency card that your child has asthma. In order to give the appropriate care, we request that you complete this form and return it to the school nurse immediately. This information will be used to develop an individual action plan for your child.

If there is any change in this information during the school year, please notify the school nurse in writing.

Thank you,

Certified School Nurse

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

<input type="checkbox"/> Coughing	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Breathing difficulty
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Thickened speech
<input type="checkbox"/> Extreme weakness	<input type="checkbox"/> Blue color of skin or lips
<input type="checkbox"/> Abdominal cramps	<input type="checkbox"/> Other _____

2. Type of Asthma: Exercise Induced _____ Allergic _____

3. Medications needed:

Name _____
Dose _____ Time _____

Name _____
Dose _____ Time _____

Special Instructions: _____

Peak Flow Zones: Green Zone _____ Yellow Zone _____ Red Zone _____

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 _____