ASTHMA CHECKLIST

1. Name of student ___________________________ Grade _______ Teacher _______________________

2. Type of asthma (Bronchial, Allergic, Exercise-induced, Other) ___________________________________

3. Asthma/allergy physician: ____
   Phone : _____________________

4. Emergency Medications: (Inhaler and nebulizer medications):

   Name _________________________ Dose___________ Times taken ______________
   Name _________________________ Dose ___________ Times taken ______________
   Name _________________________ Dose ___________ Times taken ______________

5. Medication(s) taken to control asthma:
   Name __________________________ Dose ________ Times taken ________
   Name __________________________ Dose ________ Times taken ________
   Name __________________________ Dose ________ Times taken ________

- **All medications** kept at school require medication forms signed by your child's physician and a parent/guardian.
- **Medication must be provided** by the parent/guardian.

6. Has your child been instructed in the proper use of inhalers? Yes _____ No _____

7. Does your child use a peak flow meter? Yes _____ No _____

8. How frequently do serious asthma attacks occur? _________________________________

9. Has your child been hospitalized for asthma? Yes _____ No _____
   Explain when and how often ____

10. Does your child understand asthma and what he/she should do to manage it? Yes _____ No _____

11. What restrictions does your child have on activity, if any? __________________________

12. Other comments: ____

SIGNATURE____ Date __________________