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 _____