Calvary CHRISTIAN ACADEMY

Parental Asthma Management Information
20__ to 20__ School Year

Name: _____ Grade:_____

Known Triggers

(Check the triggers that apply to the student.)

☐ Exercise	☐ Strong odors or fumes	☐ Other _____
☐ Respiratory Infections	☐ Chalk dust/dust	☐ Change in temperature
☐ Carpets in the room	☐ Animals	☐ Pollens
☐ Molds	☐ Foods _____	

Comments: _____

_____

Control of School Environment

List any environmental control measures, pre-medications, and/or dietary restrictions that the students needs to prevent an asthma episode.

_____

_____

_____

Peak Flow Monitoring – if applicable

Personal Best Peak Flow Number: _____

Monitoring Times: _____

Daily Medication Plan

	Medication	Amount	Times
1.			
2.			
3.			

*If medication will need to be given during school hours, an order from a medical provider will be needed.

Comments/Special Instructions

_____

_____

For Inhaled Medications

☐ My child has been instructed in the proper way to use his/her inhaler. I give my permission for _____ to carry his/her inhaler during school hours. I understand I need to provide a medical provider's signature stating so. Please refer to Action Plan or provider's note for signature.

☐ I do not give _____ permission to carry his/her inhaler.

_____

Parent/Guardian Signature Date