

**MARPLE NEWTOWN SCHOOL DISTRICT  
NEWTOWN SQUARE, PENNSYLVANIA 19073  
HEALTH SERVICES DIVISION**

**School Asthma Record**

Date \_\_\_\_\_

Dear Parent/Guardian:

You have told us that your child has asthma.

Please fill out the asthma record form on the back and return it to the School Nurse. The information will be shared with school personnel such as your child's classroom teacher(s) and physical education teacher on a need to know basis. The information will help them work with your child to minimize unnecessary restriction of activity and feeling of being treated differently.

Please let the nurse know of changes in your child's asthma management or medication schedule so we can help to keep your child healthy.

Thank you for your cooperation,

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Telephone

**MARPLE NEWTOWN SCHOOL DISTRICT  
NEWTOWN SQUARE PENNSYLVANIA 19073  
HEALTH SERVICES DIVISION**

**School Asthma Record**

Child's name \_\_\_\_\_ Grade/Teacher \_\_\_\_\_

Parent's name \_\_\_\_\_ Phone (home) \_\_\_\_\_  
(cell) \_\_\_\_\_ (work) \_\_\_\_\_

Physician treating child's asthma \_\_\_\_\_ Phone \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

1. Briefly describe what triggers your child's asthma symptoms.
2. Does your child do breathing exercises to reduce asthma symptoms?
3. In which sports may your child **NOT** participate?
4. Does exercise induce episodes of asthma? (If so, list types of exercise.)
5. Do certain weather conditions affect your child's asthma? (If so, list them.)
6. What medications\* help to relieve your child's asthma symptoms? Please specify dose and how given. \*
7. List any side effects your child may experience from the above medication.
8. If your child does not respond to medication, what action do you want school personnel to take?

Comments:

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date