KINGSTON ELEMENTARY SCHOOL
SILVER LAKE REGIONAL SCHOOL DISTRICT

ASTHMA RECORD

Child's Name __________________________________ Date______________________________

Parent's Name__________________________________ Phone (home)______________________

Address____Phone (work) ______________________

Physician treating child's asthma ______________________________ Phone ________________

1. Briefly describe what causes the child's asthma symptoms:

____

2. Does he/she do breathing exercises that are helpful in managing the asthma?

____

3. In which sports can the child fully 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. Name the medications taken routinely, the dose, how often taken, when, and under what circumstances additional doses should be given.

____

7. Does your child suffer any side effects to these medications? (If so, list them.)

____

8. Does your child understand asthma and what he/she should do to manage it?

____

9. How do you want the school to treat an episode of asthma if it should occur?

____

10. Approximately how often does the child have an episode?

____

11. If your child does not respond to medication, what action does the parent/guardian advise school personnel to take?

____

COMMENTS:

____

____

____

Signature of Parent/Guardian ____

PLEASE NOTE: Special forms are necessary for medication administration in school. Please contact the school nurse at your child's school. Thank you for your cooperation.

KINGSTON ELEMENTARY SCHOOL
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ASTHMA ACTION PLAN

Student Information:

Name of Student ____D.O.B.________________

Grade____________________ Homeroom Teacher of Class _____________________________

Physical Education Days and Times____

Emergency Information:

Parent/Guardian Name ____

Mother (W) _____________________________ Father (W) ____________________________

Telephone (H) ___________________________ Telephone (H) _________________________

Physician's Name __________________________________Telephone ___________________

In case of emergency, contact:

1. ____

2. ____

3. ____

Asthma Emergency Action:

The following are possible signs of an asthma emergency:

- difficulty breathing, walking, or talking
- blue or gray discoloration of the lips or fingernails
- failure of medication to reduce worsening symptoms

These signs indicate the need for emergency medical care. The steps that should be taken are:

- activate the emergency medical system in your area; Phone: 911
- call parent/guardian or physician

Triggers: ____

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KINGSTON ELEMENTARY SCHOOL
MASSACHUSETTS UNION NO. 31
and
SILVER LAKE REGIONAL SCHOOL DISTRICT

MEDICATION ORDER AND AUTHORIZATION FORM

Date______________________________

PHYSICIAN'S ORDER

Name of Student____ DOB ____________________

Grade and Teacher ____

Medication ____

Dosage____

Route____

Time to be Administered ____

Side Effects____

Date of Order _________________________ Discontinuation Date _________________________

Drug or Food Allergies____

Physician's Signature____

Physician's Address and Phone Number____

____

PARENT/GUARDIAN AUTHORIZATION

I hereby request and authorize the School Nurse to give my child __________________________
the medication ordered above by his/her physician.

I also authorize the teacher of my child to dispense his/her medication during any field trips during the school year.

Parent/Guardian Signature________________________________ Date ____________________

Address ____ Phone ____________________