CONCORD MIDDLE SCHOOL

Concord, Massachusetts

SCHOOL ASTHMA RECORD

Stu	dent Name:			Date:	
Но	Last me Address:	First	Middle	e	
				Cell/car:	
Pri	mary Physician's Name:			Phone:	
ar	nd Address:				
1.	. Briefly describe your child's asthma sysmptoms:				
2.	Does he/she do breathing exercises the	at are helpful in m	anaging the asthn	na?	
3.	Is your child able to fully participate	in sports?			
4.	Do certain weather conditions affect	your child's asthma	a? (If so, list then	n.)	
5.	Does exercise induce episodes of asth	nma? (If so, list the	e exercises.)		
6.	Describe the daily asthma medication	regimen:			
7.	Does your child suffer any side effect	ts to these medicati	ons? (If so, list th	nem.)	
8.	Does your child understand asthma ar	nd his/her managen	nent of asthma?		
9.	How do you treat a mild episode ("att				
10.	How do you treat a more serious episo	ode ("attack")?			
11.					
12.	Please outline what you would like do	one if your child ha	as a mild episode	of asthma/a serious episode of asthma?	

(Please use reverse side for additional comments.)