Asthma Form

CHIPPEWA VALLEY SCHOOLS

19120 Cass Avenue, Clinton Township, MI 48038

(586) 723-2000 FAX (586)723-2001

"Chippewa Valley Schools…preparing students today for the challenges of tomorrow"

This plan will be shared with all staff working with the student

Student: _____ School Year:_____

Birth Date: _____ School: _____

Grade: _____ Teacher: _____

Parent #1: _____ Parent # 2: _____

Parent/ Guardian #1 Telephone-Home _____Work_____Cell_____

Parent/ Guardian #2 Telephone-Home _____Work_____Cell_____

STUDENT PICTURE

TO BE COMPLETED BY PARENT

1. What are your child's signs and symptoms of an asthma attack? (check all that apply)
   ____ coughing ___ shortness of breath
   ____ wheezing ___ other (please list) _____
   ____ chest tightness _____

2. What triggers your child's asthma attacks? (check all that apply)
   ____ illness ____ cigarette smoke
   ____ cold weather or weather changes ____ chemical odors
   ____ exercise ____ emotional upset
   ____ animals (please list) _____
   Other (please list) _____
   ALLERGIES (please list) _____

3. Does your child use a peak flow meter? _____ Yes ____ No
   Child's personal best peak flow reading? _____
   Does your doctor recommend a peak flow meter be kept at school? _____

_____ _____

PARENT/Guardian Signature Date

TO BE COMPLETED BY CHILD'S PHYSICIAN

WHAT TO DO IN AN ACUTE ASTHMA EPISODE…….

1.
2.
3.
CALL 911 IF: "SIGNS OF AN ASTHMA EMERGENCY" on reverse side and list below any additional symptoms the child may present with:

Student's Physician: _____ Physician telephone: _____

If medication is needed during the school day the Request for Medication form is required to be completed by parent and physician. SEE OTHER SIDE