PHYSICIAN'S REPORT ON CHILD WITH ASTHMA

(Last Name) (First) (Middle) (BD) (ID Number))

Home Address Zip Code Other Town

Father's Name Mother's Name Telephone

School Grade Non-Attending

Dear Doctor,

The St. Stanislaus Kostka School is requesting your cooperation in completing the following questions. Please return this form to the above child's school and retain a duplicate copy for your files. __

Asthma Severity

☐ Mild Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Triggers

☐ Pollen ☐ Mold ☐ Dust ☐ Animal Dander ☐ Food (s) _____

☐ Exercise ☐ Stress ☐ Carpet ☐ Chalk Dust ☐ Other _____

☐ Respiratory Infections ☐ Change in temperature

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		
4.		

Does the Student use any of the following aids?

☐ Holding chamber ☐ Holding Chamber w/mask ☐ Mask ☐ Other _____

Peak Flow Meter

Personal Best _____ Monitoring Time (s) _____

Green Zone _____Yellow Zone (Take Rescue Meds) _____ Red Zone (Medical Alert) _____

Special Needs: *(check all that apply)*

☐ P. E. / Exercise Modification ☐ Transportation ☐ Rest Periods

☐ Special Diet ☐ Recess / Field Trips ☐ Animals in class ☐ Other

Please Explain _____

Physician's Name_____ **Hospital Affiliation** _____

(Please print or type)

Address _____**Telephone #** _____ **Fax #**_____

Physician's Signature _____**Date** _____

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