Coatesville Area School District
Parent/Guardian Questionnaire for Students with Asthma

Student Name____School_______________

School Year _________________ Grade _________________ Date ________________

Dear Parent/Guardian,
You noted on the emergency card that your child has asthma. In order to give the appropriate care, we request that you complete this form and return it to the school nurse immediately. This information will be used to develop an individual action plan for your child.
If there is any change in this information during the school year, please notify the school nurse in writing.

Thank you,

Certified School Nurse

Symptoms student has experienced in the past. (please check all that apply)

___Coughing ___Wheezing
___Hoarseness ___Breathing difficulty
___Dizziness ___Thickened speech
___Extreme weakness ___Blue color of skin or lips
___Abdominal cramps ___Other _______________

2. Type of Asthma: Exercise Induced______ Allergic ______

3. Medications needed:
Name ____
Dose _____________________ Time __________________

Name ____
Dose _____________________ Time ___________________

Special Instructions: ____

Peak Flow Zones: Green Zone ______ Yellow Zone _______ Red Zone ______

Name of Physician _______________________________ Phone Number____________

I understand the above information will be used in an emergency action plan for my child. I give my permission to share this plan with my child's assigned teachers and appropriate personnel.
Signature of Parent/Guardian_________________________________ Date___________