Scoil Mhuire Maigh Cuilinn

Asthma Record Sheet

Child's Name				
Class				
Teacher				
MY CHILD IS ASTHMATIC	**YES**		**NO**	

IF YOU ANSWERED YES ABOVE, PLEASE PROVIDE THE FOLLOWING INFORMATION. IF YOU ANSWERED NO, PLEASE STOP. PLEASE RETURN TO YOUR CHILD'S TEACHER.

MY CHILD HAS A CURRENT DIAGNOSIS OF ASTHMA	**YES**		**NO**			
DEGREE OF SEVERITY	Mild		Moderate		Severe	
Doctor's Name						
Doctor's Phone						
Consultant's Name (if applicable)						
Consultant's Phone (if applicable)						
Asthma Triggers						
Reliever Medication		**Given to School?**				
		Yes		**No**		
Reliever Medication Expiry Date						
How to Take Reliever Medication						
Controller Medication		**Given to School?**				
		Yes		**No**		
Controller Medication Expiry Date						
How to Take Controller Medication						
Any Other Relevant Information						

I agree that the medical information contained in this plan can be shared with individuals involved with my child's care and education, including medical personnel and emergency services. I understand that I must notify the school in writing of any changes to this information.

Signed	
Date	