ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

To the Parent/Guardian of:

School records specify that your child has **ASTHMA**. In order to provide better health services to your child in school, we need to know if this is currently a problem and if your child needs special observation for this condition in school. Please complete this form and return to the school.

If you have any questions or concerns, please feel free to contact me at **904-547-3802.** All medical information is confidential and will be shared only with the teaching staff working with your child. Thank you.

_____
School Nurse **(WEBSTER – Nina Hall, RN)**

Your child's asthma is triggered by (Check all that apply):
_____ Allergies such as: _____Plants _____Dust _____Animals____Other:_____
_____Exercise _____Cold air _____Weather Changes _____Infections/Bronchitis

Your child's signs of asthma or an asthma attack are (check all that apply):
_____Rapid, labored breathing _____Coughing _____Wheezing _____Tightness in chest
_____Shortness of breath _____Other (Please specify) _____

Your child's asthma is treated by (check all that apply):
_____ Regular medications, every day
_____ Medications when an attack occurs
_____ Nebulizer treatments every day
_____ Nebulizer treatments when an attack occurs
_____ I haven't had to treat the asthma since:_____
If your child uses a Peak Flow Meter, what is his/her range?_____
Please list your child's medication:_____
_____

If these medications need to be available during school hours, a Medication Authorization Form will need to be completed. Obtain forms from the school clinic

Who is the physician treating your child? _____

When was the last time your child saw the physician?_____

_____ _____
Signature of Parent/Guardian Date

IF YOUR CHILD IS NO LONGER BEING TREATED FOR THIS CONDITION AND YOU WOULD LIKE IT REMOVED FROM THE SCHOOL RECORDS, PLEASE SIGN BELOW AND RETURN TO THE SCHOOL NURSE.

_____ _____ _____
Parent/Guardian Signature Printed Name of Parent/Guardian Date