Penn-Trafford School District
P.O. Box 530 Harrison City, PA 15636
Phone: 724-744-4496 or 724-744-2121
www.penntrafford.org

ASTHMA MANAGEMENT PLAN

Dear Parent/Guardian:

Our records currently indicate your child has Asthma. Please complete this form and return it as soon as possible. We will update your child's record and be able to provide them the necessary care.
Thank you.
PTSD School Nurse

STUDENT NAME: **GRADE:** **HR:**

How long has your child been diagnosed with asthma? _____

What may trigger an asthma attack in your child? _____

_____

Has your child had any ACUTE asthma attacks requiring treatment at the hospital in the past year? (if yes, please explain) _____

_____

Does your child carry an inhaler? YES _____ / NO _____

If yes, name of prescribed medication: _____

Dosage: _____ Indication for use: _____

Does your child use a peak flow meter? YES _____ / NO _____

Further explanation if necessary _____

Please list all current medications your child takes:

Name of Medication	Dosage	Time Taken

Please add any additional information or instructions that you or your physician may feel the nurse/teacher would need to know in order to care for your child: _____

_____

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Parent/Guardian Signature: _____

Phone (home): _____ (work): _____ (cell): _____

lap:8/18