

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 School Nurse of Chicago Public Schools 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. _____

School Nurse

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 _____