

# + teacher/counselor form

# asthma

Our child

**Has ASTHMA**

Other Medical Concerns


Asthma action plan is located

Asthma medicine/s (eg. inhaler, nebulizer, sprays) are located

Other



## OUR EMERGENCY CONTACT INFORMATION

|       |   |   |
|-------|---|---|
| Mom   |    |    |
| Dad   |   |   |
| Other |  |  |

## PHYSICIAN EMERGENCY CONTACT INFORMATION

Name

Phone

|                           |     |           |         |
|---------------------------|-----|-----------|---------|
| In case of emergency call | 911 | Physician | Parents |
|---------------------------|-----|-----------|---------|

Notes

**+ Signs of asthma:**  
**WHEEZING, EXCESSIVE COUGHING, DIFFICULTY BREATHING**

Thank you for your help



Puffer