Asthma / Breathing Problem Visit Notification

Date __________Time __________

Dear Parent or Guardian of: ________________________________ Room/grade __________________

Your child was seen in the health office with asthma or breathing problems with the following symptoms:

☐ wheezing
☐ persistent coughing
☐ shortness of breath / trouble breathing / tight chest
☐ peak flow in the yellow zone
☐ peak flow in the red zone
☐ other ____________________________

The following care was given:

☐ quick relief medicine given ☐ Inhaler ☐ nebulizer
☐ rest
☐ other ____________________________

Your child:

☐ Had a peak flow reading that: ☐ stayed in the __________________ zone after treatment
☐ returned to the __________________ zone after treatment
☐ returned to class
☐ remained in the health office
☐ other ____________________________

Because an asthma episode may happen again, please observe your child closely.

☐ Please make an appointment for your child to be seen at her/his clinic (bring this form with you).
☐ Ask your Health Care Provider for a new or updated Asthma Action Plan (fax to ____________).
☐ Ask your Health Care Provider regarding the need for, or adjustment of, medication/s.
☐ For your information only
☐ Other ____________________________

When your child sees a Health Care Provider for asthma, please tell the school health office. Please let us know of the plan for your child’s asthma care and give us a copy of the Asthma Action Plan so we can better care for your child at school. If you have questions, please call: ____________________.

________________________
Licensed School Nurse

Adapted From: Minneapolis Healthy Learners Board Asthma Initiative

Notification sent:
☐ Student ☐ US Mail ☐ Telephone