NWCA Head Start/Early Head Start
312 N. Main P.O. Box 67
Badger, MN 56714
218-528-3227 800-568-5319

Asthma Record

Last Name	First	Middle	Birth Date

Physician treating child's asthma: Name_________________________ Telephone #__________________

1. Briefly describe your child's signs and symptoms of an asthma episode.

   Early signs:

   Late signs:

2. Briefly describe what triggers your child's asthma (for example - exercise, weather changes, allergies, smoke, animals, viral infections).

3. Approximately **how often** does your child have an asthma episode?

4. Does your child understand his/her asthma and know how to manage it, including treatments other than medications? Describe.

5. Does your child cooperate with treatment?

6. List medications taken routinely. ***Medication Permission Form** required if medication is to be given at Head Start centers.

7. Does your child have any **side effects** to these medications? If yes, describe:

8. What, if any, special instructions do you have if your child has an asthma attack?

Parent Signature ____ Date __________________