Forest Lake
EDUCATION CENTER

ASTHMA TREATMENT/MED Form

Student Name _____ Grade/Age _____ Date of Birth _____

Primary Contact Person _____ Phone _____

Allergies _____ Asthma Triggers _____

To Be Completed by Physician:

Current Asthma Condition: [ ] Intermittent [ ] Persistent [ ] Exercise Induced

The above student has been diagnosed with asthma and, on occasion, will require the following Asthma medication to be administered at school:

Medication to be administered via inhaler
Drug: _____
Dose: _____
Frequency: _____

Medication to be administered via nebulizer
Drug: _____
Dose: _____
Frequency: _____

Other Asthma Medication:
Drug: _____
Dose: _____
Frequency: _____

The student has been instructed and demonstrates proper technique to administer his/her asthma medication. Yes _____ No _____

The student may carry and self-administer his/her inhaler during the school day. Yes _____ No _____

Location of Inhaler at School: _____

I understand that FLEC does not have access to peak flow meters at this time.

Parent's Signature and Date

Health Care Provider's Signature Date

Health Care Provider's Phone Number

Printed Name of Health Care Provider

All medications must be received in original containers. Parents/guardians must deliver & pick up medications. Any medication left over at the end of the school year will be disposed of if it is not picked up.