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.