



Building a firm foundation through Christ-centered education

You have notified the school that your child has Asthma. In order to determine any special needs for your child, we request that you provide us the following information. Please return to school as soon as possible.

Student's Name \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Student's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Legal Guardian #1 \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Name of Legal Guardian #2 \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Has your child received a diagnosis of Asthma by an Authorized Health Care Provider? \_\_\_\_Y \_\_\_\_N

If yes, what year/ age? \_\_\_\_\_

Is your child currently under a doctor's care for Asthma? \_\_\_\_ Yes \_\_\_\_ No

Care Provider's name \_\_\_\_\_ Phone Number \_\_\_\_\_

What medication does your child take to for Asthma:

Name	Frequency
_____	_____
_____	_____
_____	_____
_____	_____

Please rate the severity of your Child's Asthma

(Not Severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

Which of the following can trigger Asthma Symptoms for your child? (Circle)

Grass Food Allergy Seasonal Allergies Animal Hair  
Physical Activity Emotional Drug Allergy Weather related Other: \_\_\_\_\_

How long does an asthma attack last for your child \_\_\_\_\_. Does your child have any restrictions?  
\_\_\_\_\_.

What helps your child when they are having an Asthma attack? (Medication, Positioning, Liquids, breathing exercises, etc.) \_\_\_\_\_  
\_\_\_\_\_

If your child requires medication to be given during school hours, please have an authorized care provider fill out the attached form. If you have any questions, do not hesitate to contact our Health Office Manager, Mrs.Matus.

p: 714.437.1700, ext. 179 | f: 714.437.7976  
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Mariners Christian School Health Office | [kmatus@marinerscs.org](mailto:kmatus@marinerscs.org) | [www.marinerscs.org](http://www.marinerscs.org)