Date

Home Address of Student

Dear _____,

According to school health information, your child, _____, has been identified as having a history of asthma. To better meet your child's needs at school, please complete and return the enclosed form by _____. This form enables school health personnel to administer needed medication to your child at school, as determined by your child's health care provider. It also enables the appropriate treatment of your child's asthma during an emergency situation. Please be certain to answer the six questions indicated with an asterisk (*), as this will help us to determine the seriousness of your child's asthma.

Please sign and return the form to school with your child. If medications are needed at school and/or if you have answered yes to any of the questions preceded by an asterisk, please call me at _____ to discuss your child's asthma care further. I look forward to working with you and your child.

Sincerely,

_____
School Nurse

_____
School Nurse email

_____
School Nurse contact number

_____
School Nurse fax number