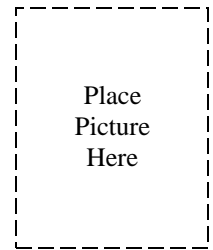


ASTHMA NOTICE



Student Name: _____

Birth Date: _____

Diagnosed Medical Condition: _____

How often does the condition occur? _____

The following are **triggers** of the condition:

Early Symptoms may include:

Late Symptoms may include:

Routine or As Needed Treatment and Medication:

If any medication is to be administered, please also complete the *Permission to Administer Medication* Form.

Emergency Treatment and Medication (if child does not respond to medication):

If any medication is to be administered, please also complete the *Permission to Administer Medication* Form.

Child's Knowledge of Condition:

1. Can your child tell the teacher when treatment and medication is needed? Yes No
2. Does your child cooperate with treatment and medication? Yes No

Physician's Signature _____ Date _____

I give Valley Preschool permission to display my child's medical condition and photo for teachers, volunteers, parents, and visitors to see.

Parent/Guardian Signature _____ Date _____