



## KidsArts! ASTHMA ACTION CARD

Please complete this form if your child has asthma.

1. Child's Name: \_\_\_\_\_

2. Health Care Provider who sees child for asthma, if different from child's physician  
(if same as physician listed on First Aid & Emergency Medical Care form, write "SAME"):

Physician Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Site: \_\_\_\_\_

3. Child's asthma triggers (check those which apply to your child):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Exercise        | <input type="checkbox"/> Cold Air              | <input type="checkbox"/> Heat/Humidity          |
| <input type="checkbox"/> Furry Animals   | <input type="checkbox"/> Pollen                | <input type="checkbox"/> Dust/Dust Mites        |
| <input type="checkbox"/> Strong Emotions | <input type="checkbox"/> Pollution             | <input type="checkbox"/> Respiratory Infections |
| <input type="checkbox"/> Carpeting       | <input type="checkbox"/> Cockroaches           | <input type="checkbox"/> Perfumes/Odors         |
| <input type="checkbox"/> Cigarette Smoke | <input type="checkbox"/> Other (Explain) _____ |   |

4. Daily Medications:

Medications	Amount	When to Use
_____		
_____		
_____		

5. Where is your child's inhaler kept  
(for example, in the KidsArts! office, in his/her backpack, etc.)?

\_\_\_\_\_

6. Is your child able to use the inhaler without assistance? \_\_\_\_\_

7. Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_