ASTHMA QUESTIONAIRE

Dear Parent;

You have noted on your child's emergency card that he/she has asthma. To assist us in anticipating and treating an asthma episode at school, please complete the following health information and return it to the school as soon as possible.

Child's Name: _____ Date of Birth: _____

Teacher: _____ Grade: _____

Parent/Guardian: _____ Phone: (H)_____ (C) _____

Severity of Asthma:

1. My child has asthmatic symptoms that requires medication:
   - □ Daily
   - □ Weekly
   - □ Monthly
   - □ Several times/year or less
2. My child's last medication for asthma was (date) _____.
3. The last time my child needed to use quick relief medication (i.e., Albuterol, Proventil, etc.) was (date) _____.
4. My child has required asthma medication/treatment either in the emergency room or been hospitalized (please list dates and indicate whether an emergency room visit or hospitalization)

   _____, _____, _____

4. Yes ___ No ___ My child carries asthma medication with him/her at all times and independently self-administers.
5. Yes ___ No ___ My child needs assistance with medication administration.

Triggers

Identify what may cause an asthma attack (if known). Check each that applies to your child.

□ Exercise	□ Flowers	□ Molds
□ Cold weather	□ Bushes	□ Animal fur or feathers
□ Chalk Dust	□ Trees	Type: _____
□ Dust mites	□ Respiratory infection	□ Strong odors or fumes
□ Air pollution	□ Changes of weather	□ Pollens _____
□ Paint	□ Cockroaches	□ Food _____
□ Smoke	□ Perfume	□ Other _____

List any environmental control measures, medications, and/or dietary restrictions that the student needs to follow to prevent an asthma episode _____

_____

_____

_____

Asthmatic Symptoms

My child has the following symptoms:

- □ Coughing
- □ Wheezing
- □ Chest tightness
- □ Vomiting
- □ Rapid breathing
- □ Can not walk, talk or move well
- □ Blue skin coloring around the lips or nails
- □ Other _____

Treatments:

List all medications used either daily or as quick relief:

Name	Amount	Route/Method	When used	Side Effects
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Steps taken at home during an asthma episode:

1. Medications given: _____ _____ _____
2. Response time to the medication: _____
3. Other interventions: _____
4. When 911 is called at home _____ Date of last 911 call _____

Special Precautions:

_____

_____

_____ _____

Parent/Guardian Signature Date

Updated 08/31/06