

GEO Prep Asthma Assessment Questionnaire

Student: _____ D.O.B.: _____ Grade: _____

Parent/Guardian: _____ Phone#: _____

Emergency Contact: _____ Phone #: _____

Physician: _____ Hospital of Choice: _____

Currently prescribed medications and treatments: _____

Will the child have medication at school? Yes No

If yes, please have the doctor fill out the necessary forms. (Forms are available at school)

If no, what actions do you want the school to take if the child has an asthma attack?

What triggers the asthma attack?

- Environmental (i.e., dust, pets, pollen, strong smells, etc.)
- Exercise
- Extremes in temperature
- Upper respiratory infections
- Other: _____
- Allergies (please list): _____

What symptoms does your child have?

- Chest tightness, discomfort, or pain
- Difficulty breathing
- Coughing
- Wheezing
- Other _____

What helps to relieve these symptoms? _____

Date of last hospitalization related to asthma: _____

Date of last emergency room visit related to asthma: _____

I am aware that if my child requires emergency care at school and I am not available, the school's principal or alternate will have my child transported to the emergency room. I will be responsible for payment of emergency care.

Parent/Guardian Signature: _____ Date: _____