



### Asthma Questionnaire

School Year: \_\_\_\_\_

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Asthma Specialist: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

1. Has your child been diagnosed with asthma by a healthcare provider?  Yes  No
2. Indicate what type of asthma your child has been diagnosed with (circle which one applies):
 

Mild Intermittent	Mild Persistent
Moderate Persistent	Severe Persistent
3. When was your child diagnosed with asthma? \_\_\_\_\_ How old was your child? \_\_\_\_\_
4. How frequently does your child experience an asthma attack? \_\_\_\_\_
5. How have past asthma attacks been treated? \_\_\_\_\_
6. Has your child ever been treated in the emergency room or hospitalized for their asthma? If so, please explain (when, how long of stay, treatment, etc): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
7. How quickly do asthmatic symptoms typically occur after exposure to triggers? \_\_\_\_\_
8. What triggers your child's asthma? (circle all that apply)
 

Dust	Mold	Pollen	Viral infections	Bee stings	Perfumes	Smoke	Exercise
Environment	Animal Dander	Other:	_____				

**Complete Back Side**



9. Please list any medication and frequency of use that your child uses to manage their asthma:

\_\_\_\_\_

10. Does your child use an inhaler/nebulizer? \_\_\_\_\_ If so, does your child know how to use their inhaler/nebulizer? \_\_\_\_\_

11. How frequently does your child use a rescue inhaler or nebulizer (daily, weekly, etc)? \_\_\_\_\_

12. Does your child require an inhaler prior to physical activity such as phy-ed or recess?  Yes  No

13. Please list any medication that your child will need during school? \_\_\_\_\_

14. Is there anything else you would like the school to know about your child's asthma? \_\_\_\_\_

\_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please note:**

- If your child has asthma, we request that you make accommodations with the health office regarding your child's medications, supplies, & signed authorizations/forms
- Please fill out and submit an *Authorization for Administration of Medication at School Form* and provider/prescriber's asthma orders/action plan to the appropriate health office
- If the parent/legal guardian and provider/prescriber feel the student can self-carry and self-administer their rescue medication, please also fill out and submit a *Self-Carry/Self-Administer Medication Authorization Form* to the appropriate health office.