ASTHMA QUESTIONNAIRE

Medic Alert Bracelet ☐YES ☐ NO

Student's Name:	Date of Birth:	School Year:
Name of Physician (for asthma):	Clinic Phone Number:	
Parent/Guardian Phone Number:		

1. At what age was your student diagnosed with asthma? _____
2. Asthma Severity: ☐Intermittent ☐Mild persistent ☐Moderate persistent ☐Severe persistent
3. Does your student have any allergies? _____
4. What best describes your student's symptoms:
   - ☐Symptoms occur daily
   - ☐Symptoms are *more* than 2 times a week, but not every day
   - ☐Symptoms are *less* than 2 times a week
   - ☐Symptoms are rare
5. How often does your student use their inhaler?
   - ☐Every day
   - ☐More than 2 times a week, but not every day
   - ☐Once or twice a week
   - ☐Before exercise or sports
   - ☐Rarely
6. What **triggers** your student's asthma episode? (check appropriate box(es)
   - ☐Illness
   - ☐Changes in weather
   - ☐Chemical odors / strong smells / perfumes
   - ☐Emotions / fatigue
   - ☐Exercise / sports / playing hard
   - ☐Other: _____
   - ☐Medications
   - ☐Cigarette or other smoke
   - ☐Food
   - ☐Animals/pets
   - ☐Chalk/chalk dust
7. What does your student do at home to relieve wheezing during an asthma episode? (check all that apply)
   - ☐Breathing exercises
   - ☐Rest / relaxation
   - ☐Drinks liquids
   - ☐Medications (circle those that apply): Inhaler / Nebulizer/ Oral medication
   - ☐Other: _____

8. How well does your student use his/her asthma **medications**? (check the appropriate box(es)

☐Has been instructed on when and how to take medication independently

☐Forgets to take medicine

☐Needs help taking medicine

☐Not using medication currently

☐Student is comfortable alerting others when experiencing asthma symptoms and reporting the need for medication

9. Has your child been treated in the emergency room or been hospitalized for asthma in the past year?

☐Yes (How many times and please explain) _____

☐No

10. Does your student usually use a spacer with inhaler use? ☐Yes ☐No

11. Please provide any other information you may think is pertinent. _____

_____

12. **Please list the medications your student uses for asthma. (include daily, prior to activity, or as needed)**

Name of Medication	Dose	Frequency

If medications are to be given during school, a medication authorization form needs to be filled out yearly. Medications, including inhalers, must be in the original LABELED container and kept in the Health office.

Prior to self-carrying their inhaler, the student may be assessed by the Registered Nurse to determine if able to self-carry.

We encourage students who self-carry their inhalers to have a backup available in the Health office.

Will you allow school health staff to share this information with other school staff ***only*** on a **"need to know"** basis? ***(All student health information is handled in a respectful & confidential manner).*** ☐Yes ☐ No

Parent Signature _____ Date _____

School Health Para Signature _____ Date_____

Registered Nurse Signature _____ Date _____