KIRKWOOD
SCHOOL DISTRICT

Asthma Questionnaire

Date _____

Dear Parent/Guardian:

Please help us to better understand your child's Asthma by completing the questionnaire below. I will share the necessary information with your child's teacher in order to protect him/her and to minimize absenteeism.

Please return the completed questionnaire to me and keep me informed of any changes in your child's asthma or medication schedule.

Sincerely,

_____, R.N. - _____ School Nurse

Child's Name _____ Parent's Name _____

Phone: _____ _____ _____
Home Work Cell

Physician treating asthma: _____ Phone _____

1. Briefly describe the frequency and cause of the asthma attacks: _____

_____

2. Does your child have any activity restriction? _____

3. Which weather conditions affect the asthma? _____

4. List the medications taken routinely: _____
(dose & frequency)

5. Under what circumstances should additional doses be given? _____

_____

6. Are any other medications ever given? _____

7. Are there any side effects to these medications? _____

8. Does your child understand how to manage his/her asthma? _____

9. What is your child's normal PEAK FLOW READING: _____

10. At what PEAK FLOW LEVEL do you:
    - administer medication and/or aerosol treatment: _____
    - contact your physician: _____

Additional comments or information: _____

_____