Wausau School District
Asthma Parent Questionnaire

Student Name _____ Grade ____ School _____

Parent/Guardian _____

Home Phone _____ Work _____ Cell _____

Primary Health Care Provider_____ Phone _____

Asthma Specialist _____ Phone _____

1. Does your child have an asthma diagnosis from a health care provider? □ No □ Yes
   Age of child at diagnosis: _____
2. How many days would you estimate your child missed school last year due to asthma?
   □ 0 days □ 1-2 □ 3-5 □ 6-9 □ 10-14 □ more than 15
3. How many times has your child required an emergency room visit or hospitalization due to an asthma attack in the past 12 months?
   □ 0 times □ 1 time □ 2 times □ 3 times □ 4 times □ 5 or more times
4. What triggers your child's asthma symptoms?
   □ exercise □ colds/flu □ smoke □ weather □ strong odors
   □ emotions □ dust □ animals □ reflux disease □ grass/flowers
   □ medications (list) _____ □ foods (list) _____
   □ allergies (list) _____ □ other (list) _____
5. Please circle your child's symptoms.

Common Symptoms:

coughing shortness of breath wheezing heavy breathing
chest tightness/pain difficulty exercising fatigue irritability
inability to talk coughing during night abdominal discomfort
changes in breathing (unusually fast/slow, unusually shallow/deep)
other_____

6. What medications does your child take to control asthma? (please list)

_____

_____

7. Does your child understand asthma and how to manage it? □ No □ Yes
   - Is your child able to monitor his/her asthma symptoms? □ No □ Yes
   - Does your child know his/her asthma triggers and how to avoid them? □ No □ Yes
   - Is your child able to tell peers and adults when having asthma symptoms? □ No □ Yes
   - Does your child know how to correctly use an inhaler independently? □ No □ Yes

8. Please add anything else you'd like the school to know about your child's health.

_____

_____

Parent/guardian signature_____ Date _____

Reviewed by_____ Date _____