



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)

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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 _____

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