



Wausau School District Asthma Questionnaire

Student name: _____ Date of birth: _____

Parent/Guardian: _____ Date: _____

Name of clinic where your child receives asthma care: _____

Provider Name: _____

1. Does your child have an asthma diagnosis from a healthcare provider? No Yes

Age of child at diagnosis: _____

2. How would you rate the severity of your child's asthma?

(Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. 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) _____

4. Are symptoms worse during a specific time of year?

5. 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

6. 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

7. Please add any additional information that would be helpful for school personnel to know:

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