Health Services Department
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ASTHMA QUESTIONNAIRE

STUDENT_____ DOB: _____

Dear Parent or Guardian:
Previously received information indicates that your son/daughter has had a problem with asthma. Please complete the following to assist us to be better prepared in the event of a problem while at school. Thank you for your assistance.

When was the most recent occurrence?_____
Please describe the symptoms he/she experienced during an attack:
Mild: _____
Severe: _____
_____

Please indicate all of the triggers associated with an attack?
Stress _____ Allergies (what) _____
Exercise (what) _____ Cold weather _____ Other _____

MEDICATION (please print) DOSAGE FREQUENCY

Daily: _____

During attack: _____

Emergency Medications: _____
Does your son/daughter understand asthma and its management? _____
Has he/she been taught proper inhaler technique? _____
How often does he/she use a Peak Flow meter? _____
Has he/she ever used a nebulizer for medication? _____
How do you treat an attack at home? _____
_____
Approx. frequency of attacks: Mild _____ Severe _____
Approx. length of attacks: Mild_____ Severe _____
Has treatment at a hospital ever been required? _____
If he/she does not respond to medications, what action has the physician recommended? _____
_____

Does your student have an Asthma Action Plan? Yes _____ No _____ If yes, please attach a copy.

Name of Physician: _____Tel. # _____

IF YOUR CHILD REQUIRES MEDICATION AT SCHOOL, THE FOLLOWING IS REQUIRED:

- A NOTE WITH SPECIFIC INSTRUCTIONS FROM THE PHYSICIAN (INHALERS TO BE CARRIED MUST BE SPECIFIED AS WELL, PEAK FLOW METERS AND NEBULIZER ARE AVAILABLE AT SCHOOL).
- A NOTE OF AUTHORIZATION FROM THE PARENT:
- PROPERLY LABELED CONTAINER(S) BROUGHT TO THE HEALTH OFFICE WITH THE ABOVE NOTES.

ALL MEDICATION NOTES MUST BE RENEWED ANNUALLY

THIS STUDENT MAY CARRY INHALER ON HIS/HER PERSON. YES ( ) NO ( )
Date: _____
Signature of Physician_____ Signature of Parent_____