Medic Alert Bracelet ___YES ___ NO

Asthma Questionnaire

Student's Name: _____ DOB: _____ School Year _____

Name of Physician and Clinic (for asthma) _____

The following information is helpful to your child's school nurse/health para in determining any special needs for your child. Please answer the questions to the best of your ability. If you desire a conference with the school nurse, please call for an appointment.

Please understand that new medication authorizations and Action Plans are required each school year. Questionnaires can be reviewed and updated, new ones required with change of school (i.e. Discovery to AAHS).

1. At what age was your student diagnosed with asthma? _____

2. Asthma Severity: □ Intermittent □ Mild persistent □ Moderate persistent □ Severe persistent

3. Does your student have any allergies? _____

4. What best describes your student's symptoms:
   - □ Symptoms occur daily
   - □ Symptoms are *more* than 2 times a week, but not every day
   - □ Symptoms are *less* than 2 times a week
   - □ Symptoms are rare

5. How often does your student use their inhaler?
   - □ Every day
   - □ More than 2 times a week, but not every day
   - □ Once or twice a week
   - □ Before exercise or sports
   - □ Rarely

6. What **triggers** your student's asthma episode? (check appropriate box(es)
   - □ Illness
   - □ Changes in weather
   - □ Chemical odors / strong smells / perfumes
   - □ Emotions / fatigue
   - □ Exercise / sports / playing hard
   - □ Medications
   - □ Cigarette or other smoke
   - □ Food
   - □ Animals/pets
   - □ Chalk/chalk dust
   - □ Other _____

7. What does your student do at home to relieve wheezing during an asthma episode? (check all that apply)
   - □ Breathing exercises
   - □ Rest / relaxation
   - □ Drinks liquids
   - □ Medications (circle those that apply): Inhaler / Nebulizer/ Oral medication
   - □ Other _____

8. How well does your student use his/her asthma **medications**? (check appropriate box(es)
   - □ Has been instructed on when and how to take medication independently
   - □ Forgets to take medicine
   - □ Needs help taking medicine
   - □ Not using medication at this time
   - □ Student is comfortable alerting others when experiencing asthma symptoms and reporting need for medication

Next Page →

9. Has your child been treated in the emergency room or been hospitalized for asthma in the past year?
   - □ Yes (How many times and please explain) _____
   - □ No

10. Does your student usually use a spacer with inhaler use? □ Yes □ No

11. Please provide any other information you may think is pertinent. _____
_____

12. **Please list the medications your student uses for asthma. (include daily, prior to activity, or as needed)**

Name of Medication	Dose	Frequency

If medications are to be given during school, a medication authorization form needs to be filled out yearly. Medications, including inhaler, must be in the original LABELED container and kept in the Health office.

Prior to self-carrying their inhaler, the student may be assessed by the Licensed School Nurse to determine if able to self-carry.

We encourage students who self-carry their inhaler to have a back-up available in the Health office.

Will you allow school health staff to share this information with other school staff ***only*** on a **"need to know"** basis? ***(All student health information is handled in a respectful & confidential manner).*** □ yes □ no

Parent Signature _____ Date _____

School Health Para Signature _____ Date _____

School Nurse Signature _____ Date _____