



# Asthma Questionnaire

To be completed by parent

Student Name _____	Date of Birth _____	School Year _____
School All Saints Academy _____	HR/Grade _____	
Parent/Guardian _____	Relationship _____	Phone _____
Parent/Guardian _____	Relationship _____	Phone _____
Emergency Contact _____	Relationship _____	Phone _____
Healthcare Provider _____	Phone _____	Fax _____

*The information will provide the school nurse with a better understanding of the child's needs.  
This questionnaire needs updated and completed each school year.*

Has this child been diagnosed with asthma by a healthcare provider?  Yes  No

**Note:** Bring medical documentation to the school nurse. **AFTER** the nurse has received documentation from the child's **healthcare provider**, school staff will be notified of the asthma and emergency plans.

**Asthma Triggers - circle and describe:**

Exercise    Illness    Weather    Smoke/Fumes/Odors    Animal \_\_\_\_\_    Other \_\_\_\_\_

Indoor allergies \_\_\_\_\_

Outdoor allergies \_\_\_\_\_

Other \_\_\_\_\_

**Early Symptoms or Warning Signs:**

Please list:

  
  

**Asthma Medicine:**

Typically, how often does your child need to use a rescue medication?

How does your child manage an asthma episode at home?  allow to rest and cool down     rescue inhaler

nebulizer     other: \_\_\_\_\_

Daily medication name:	Dosage:	When taken:
"As needed" or rescue medications:	Dosage:	How often:
<input type="checkbox"/> Albuterol MDI	90 mcg 2 puffs	
<input type="checkbox"/> Other		

**Any other information or chronic health problems that would be helpful to know?**

  
  

*If the student does not respond to medication during an episode, the school will notify the parent/guardian and call 911.*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**RETURN TO SCHOOL NURSE IMMEDIATELY**