WEST ADA SCHOOL DISTRICT
1303 E. CENTRAL DRIVE, MERIDIAN, IDAHO PHONE (208) 855-4500

ASTHMA QUESTIONAIRE

Student's Name_____ School Year_____

School_____ Grade_____ Teacher_____

Parent's Name(s)_____ Telephone (home)_____ (work)_____

Name of Child's Doctor (for asthma)_____ Telephone_____

May the nurse contact your Doctor? ☐ Yes ☐ No

The following information is helpful to your child's school nurse and school staff 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.

Nurse's Name_____ Telephone_____

1. How long has your child had asthma?_____

2. Please rate the severity of his/her asthma. (circle)

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

   What symptoms does your child have with an asthma attack?_____

3. How many days of school would you estimate he/she missed last year due to asthma?_____

4. What triggers your asthma attacks? (Please check any that apply.)

☐ Illness	☐ Emotions	☐ Medications
☐ Weather	☐ Exercise	☐ Fatigue
☐ Chemical Odors	☐ Cigarette or other smoke	☐ Food

   Allergies (please list) _____
   Other (please list) _____

5. What does your child do at home to relieve wheezing during an asthma attack? (Please check any that apply.)

   ☐ Breathing exercises ☐ Rest/relaxation ☐ Drinks liquids

   Takes medications:

   ☐ Inhaler ☐ Nebulizer ☐ Oral medication

   Other (please describe)_____

6. Please list the medications your child takes for asthma. (daily, prior to activity, or as needed)

	Name of Medication	Dose	Frequency
(At school)			
(At Home)			

If medications are to be given during school, a medication permission slip needs to be filled out yearly. Medications must be in the original labeled container and kept in the nurse's office.

7. What if any, side effects does your child have from his/her medication?

8. Has your child been taught how to use and extension tube, pulmonary aid, inspirease kit, or other devise with his/her inhaler? ☐Yes ☐No

9. How many times has your child been treated in the emergency room for asthma in the past year?

10. How often does your child see his/her doctor for routine asthma evaluations?

11. Does your child need any special considerations related to his/her asthma while at school? (Check any that apply and describe briefly.)
    - ☐ Modified gym class
    - ☐ Modified recess outside
    - ☐ No animal pets in classroom
    - ☐ Avoid certain foods
    - ☐ Emotional or behavior concerns
    - ☐ Special consideration while on field trips
    - ☐ Special transportation to and from school
    - ☐ Observation from side effects from medication
    - ☐ Other

12. What is your child's baseline peak flow rate?

13. Do you think your child holds him/herself back from participating in activities at school because of his/her asthma? If so, please describe.

14. Have you ever attended and asthma education class? ☐Yes ☐No
    Has your child ever attended an asthma education class? ☐Yes ☐No

15. Is there any additional information we should have to better manage your child's asthma?