Kimberly School District

141 Center Street West Kimberly, Idaho 83341 Phone: 208-423-4170 Fax: 208-423-6155

Asthma Questionnaire for Parents

Student Name_____ Grade/Teacher_____

Parent/Guardian Name(s) _____

Name of Doctor treating asthma_____ Clinic Phone _____

Please complete and return this form to the school nurse. Information obtained will aid in the development of an Individual Healthcare Plan for your child.

1. At what age was your child's asthma diagnosed? _____
2. What are your child's usual signs/symptoms during as asthma attack?
   □ wheezing □ cough □ difficulty breathing □ chest tightness □ anxiety □other _____
3. How many days of school would you estimate your child missed last year due to asthma?
4. In the past year, how many times has your child been treated in the emergency room for asthma symptoms?
5. In the past year, how many times has your child been hospitalized (overnight or longer) for asthma symptoms?
6. In the past month, during the day, how often has your child had asthma symptoms?
7. In the past month, during the night, how often does your child wake up or experience asthma symptoms?
8. What triggers your child's asthma symptoms?
   □ exercise □ stress □ cold air □ illness □ allergies to _____
   □smoke campfire/cigarette (Does anyone smoke at home? □ yes □ no) □ other_____
9. What does your child do at home to relieve the symptoms during an attack?
   □ rests □ drinks fluids □ uses breathing exercises □ checks peak flow □takes medication
   □other_____
10. What medications is your child using presently to control or treat asthma symptoms?

Name of medication	How much?	How often?

11. Does your child know when he/she needs medication? □ yes □ no
12. If your child uses an inhaler, does he/she use a spacer? □ yes □ no

Comments:

Parent/Guardian Signature/Date_____ School Nurse Signature/Date _____