

**East Side Union High School District
Asthma Questionnaire**

Student:	DOB:	Grade:		
School:	Information provided by:			Date:
1. How long has your child had asthma:				
2. Please rate the severity of his/her asthma. (Check) Mild = Rarely uses emergency inhaler & no emergency room visits within the past year for asthma Moderate = Uses emergency inhaler 1-3 days out of the week Severe = Uses emergency inhaler most days of the week				
3. Identify what may cause (trigger) an asthma episode. Check all that apply:				
<input type="checkbox"/> Smoke	<input type="checkbox"/> Grass/flowers	<input type="checkbox"/> Stress or emotional upsets		
<input type="checkbox"/> Animals/pets	<input type="checkbox"/> Mold	<input type="checkbox"/> Changes in weather/very cold or hot air		
<input type="checkbox"/> Dust/dust mites	<input type="checkbox"/> Strong smells/perfumes	<input type="checkbox"/> Exercise		
<input type="checkbox"/> Cockroaches	<input type="checkbox"/> Foods:	<input type="checkbox"/> Other:		
	<input type="checkbox"/> Having a cold			
4. Check individual symptoms of an asthma episode:				
<input type="checkbox"/> Coughing	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Chest/throat tightness		
<input type="checkbox"/> Breathing hard & fast	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Child's verbal complaints:		
	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Other:		
	<input type="checkbox"/> Mouth breathing			
5. Medications your child takes for asthma (everyday and/or as needed): * Additional medications/information can be added to the back of the form				
<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Inhaler/Nebulizer/Oral</u>	<u>When Needed?</u>
1.				
2.				
Does your child need medication at school? No Yes				
* If Yes , provide a <i>School Medication Administration Authorization</i> form completed by a physician and a guardian for each medication. If your child needs to carry emergency medication at school also provide an <i>Authorization to Carry and Self-Administer Emergency Medication on Campus</i> form completed by a physician and a guardian. Consider talking with your child's physician about creating an asthma action plan.				
6. Does your child routinely use an inhaler before PE/exercise? No Yes				
7. How many times has your child been treated in the emergency room for asthma in the past year?				
_____			_____	
Parent/Guardian Signature			Date	

*Please return completed form to the school Health Office.