Asthma Questionnaire

To be completed by parent

Office of the School Nurse
1285 Zettler Road, Columbus Ohio 43227

Student Name		Date of Birth		School Year	
School		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:**
☐ Albuterol MDI	90 mcg 2 puffs	
☐ 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