KUNA SCHOOL DISTRICT #3
1450 BOISE STREET KUNA, ID 83634 . PHONE (208) 922-1000

ASTHMA QUESTIONNAIRE

Date: ______________________ School: ___________________________

Student's Name: ____________________ Birth date: ____________ Teacher/Grade: ___________
Parent/Guardian Name: ____

Address: ____

Phone (H): ___________________ (W) ______________________(C)_______________________

Parent/Guardian Name: ____

Address: ____

Phone (H): ___________________ (W) _______________________(C)______________________

Physician Child Sees for Asthma: ____

Address: ____

Phone: ____

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:______________________

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1. How long has your child had asthma? ____________________________

2. Rate the severity of his/her asthma: ____Mild ____Moderate ____Severe

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

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

4. What triggers your child's asthma attacks?

   ____Illness _____Emotions ______Medications
   ____Weather _____Exercise ______Fatigue
   ____Chemical Odors ______Food ______Cigarette or other smoke

   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.**

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

8. Has your child been taught how to use an extension tube, pulmonary aid, inspirease kit, or other device for 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. Does your child need any special considerations related to his/her asthma while at school? (Check any and all that apply and describe briefly)
- ☐ Modified gym class____
- ☐ Modified recess outside____
- ☐ No animal or pets in the classroom____
- ☐ Avoid certain foods____
- ☐ Emotional or behavioral concerns____
- ☐ Special considerations while on field trips____
- ☐ Special transportation to and from school ____
- ☐ Observation from side effects from medication ______________________________________
- ☐ Other____

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

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

13. Have you ever attended an asthma education class? _____Yes _____No
Has your child ever attended an asthma education class? _____ Yes _____ No

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