Parent Questionnaire: Asthma

Child Information

Name: ____ Date of Birth: _______________

Teacher: ____ Grade: _______________________

Allergies: ____

Emergency Information

Parent's or Guardian's Names: ____

Mother's Telephone (H): _________________ (W): _________________ (C): _________________

Father's Telephone (H): _________________ (W): _________________ (C): _________________

Physician: ______________________________________ Telephone: _______________________

In the event a parent/guardian cannot be reached:

1. _____________________________ Relation: _______________ Telephone: _______________
2. _____________________________ Relation: _______________ Telephone: _______________

Preferred Hospital: ____

Date of Last Asthma Episode: _________________

Triggers that may bring on an asthma episode:

☐ Cigarette smoke ☐ Exercise ☐ Exposure to cold air ☐ Odors

☐ Emotional Stress ☐ Respiratory Infections ☐ Paint Fumes

☐ Allergic reaction, such as food or insects (describe) _____________________________________

____

☐ Other (pollens, dust, mold, animals, etc.) ____

____

Signs and Symptoms: (Please check the symptoms that occur in your child.)

☐ Cough ☐ Tired ☐ Wheezing ☐ Fear ☐ Chest Tightness ☐ Shortness of Breath

☐ Agitation ☐ Bluish color to skin/lips/nails ☐ Unable to speak without taking a breath

☐ Other ____

Does your child use a peak flow meter? ________Yes ________No

If yes, Daily ________ Occasionally ________ Base line Peak Flow ________

Other Chronic illnesses/disabilities: ____

ALL CURRENT MEDICATIONS

Medication	Dosage	Time Given	Purpose	Comments

I understand that it is my responsibility to keep this information current. I will notify the School Nurse of changes and provide an updated/ current form on an annual basis.

Parent's/ Guardian's Signature ______________________________Date ______________