Wausau School District
Asthma Parent Questionnaire

Student Name ___________________________ Grade ____ School ________________
Parent/Guardian ____
Home Phone _________________ Work _________________ Cell __________________
Primary Health Care Provider________________________ Phone __________________
Asthma Specialist _________________________________ Phone __________________

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1. Does your child have an asthma diagnosis from a health care provider? □ No □ Yes
   Age of child at diagnosis: ______
2. How many days would you estimate your child missed school last year due to asthma?
   □ 0 days □ 1-2 □ 3-5 □ 6-9 □ 10-14 □ more than 15
3. How many times has your child required an emergency room visit or hospitalization due to an asthma attack in the past 12 months?
   □ 0 times □ 1 time □ 2 times □ 3 times □ 4 times □ 5 or more times
4. What triggers your child's asthma symptoms?
   □ exercise □ colds/flu □ smoke □ weather □ strong odors
   □ emotions □ dust □ animals □ reflux disease □ grass/flowers
   □ medications (list) _______________________ □ foods (list) _____________________
   □ allergies (list) __________________________ □ other (list) _____________________
5. Please circle your child's symptoms.

Common Symptoms:			
coughing	shortness of breath	wheezing	heavy breathing
chest tightness/pain	difficulty exercising	fatigue	irritability
inability to talk	coughing during night	abdominal discomfort	
changes in breathing (unusually fast/slow, unusually shallow/deep)			
other____			

6. What medications does your child take to control asthma? (please list)
   ____
   ____
7. Does your child understand asthma and how to manage it? □ No □ Yes
   - Is your child able to monitor his/her asthma symptoms? □ No □ Yes
   - Does your child know his/her asthma triggers and how to avoid them? □ No □ Yes
   - Is your child able to tell peers and adults when having asthma symptoms? □ No □ Yes
   - Does your child know how to correctly use an inhaler independently? □ No □ Yes
8. Please add anything else you'd like the school to know about your child's health.
   ____
   ____

Parent/guardian signature___________________________________ Date ______________
Reviewed by____ Date ______________