HEALTH SERVICES

Coopersville Area Public Schools

**Asthma History Questionnaire**

Student:       Date of Birth:       Grade:

|  |  |  |  |
| --- | --- | --- | --- |
| **Emergency Contact Information** | Relationship | Primary Phone # | Secondary Phone # |
| 1. |       |       |       |       |
| 2. |       |       |       |       |
| 3. |       |       |       |       |
| Doctor |       |       |       |  |

When was your child diagnosed with asthma?

Please rate the severity of his/her asthma. (not severe) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 (severe)

What triggers your child’s asthma attacks? Check all that apply.

[ ]  Allergies [ ]  Fatigue [ ]  Weather changes [ ]  Cigarette/smoke [ ]  Emotions

[ ]  Exercise [ ]  Illness [ ]  Medications [ ]  Chemical odors [ ]  Food

How many days would you estimate they have missed school last year due to asthma? [ ]  0 [ ]  1-5 [ ]  6-10 [ ]  15+

Does your child use a Peak Flow Meter at home? [ ]  Yes [ ]  No If yes, what is their personal best?

What does your child do at home to relieve wheezing during an asthma attack? Check all that apply.

[ ]  Inhaler [ ]  Nebulizer [ ] Other medication [ ]  Rest [ ]  Liquids [ ]  Breathing exercises

[ ]  Other, please describe:

|  |
| --- |
| **What medications does your child take?** |
| Medication:       | How often? [ ]  Daily [ ]  As needed [ ]  Before exercise |
| Does this medication need to be given at school? [ ]  Yes [ ]  No |
| Medication:       | How often? [ ]  Daily [ ]  As needed [ ]  Before exercise |
| Does this medication need to be given at school? [ ]  Yes [ ]  No |
| Medication:       | How often? [ ]  Daily [ ]  As needed [ ]  Before exercise |
| Does this medication need to be given at school? [ ]  Yes [ ]  No |

*\*A separate request for medication administration is required for each medication to be given at school. If your student takes more medications than can fit within the table, please attach a separate sheet.*

How many times has your child been treated in the Emergency Department for his/her asthma in the last year?

Has he/she been hospitalized for asthma-related problems within the last year? [ ]  Yes [ ]  No How many times?

Does your child need any special considerations related to his/her asthma while at school? [ ]  Yes [ ]  No

If yes, please explain:

Thank you for taking the time to complete this form concerning your child’s asthma needs. Please inform the school nurse if there are any changes to your child’s asthma treatment plan during the year.

Please email this form to Nurse Caley at **ctenbrink@capsk12.org**