Ankeny Christian Academy
Phone (515) 965-8114
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Asthma Questionnaire

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Student's Name _____ DOB _____ Grade/School Year_____
Name of Health Care Provider _____ Phone Number _____

Provider Address _____ Date of Asthma Diagnosis _____

1. Please circle if your child's asthma is severe or not severe or anywhere in between (circle #) 1 2 3 4 5
   Not severe Severe
2. What are your child's usual signs / symptoms during an asthma attack?
   □ wheezing □ coughing □ difficulty breathing □ chest tightness □ anxiety
   □ other_____
3. What does your child do at home to relieve symptoms during an asthma attack?
   □ rests □ drinks fluids □ uses breathing exercises
   □ checks peak flow □ takes medication □ other_____
4. Please list the medications your child takes for asthma or allergies (every day and as needed) _____
   _____
5. How many days did your child miss school **last year** due to his/her asthma?
   □ 0 days □ 1-2 days □ 3-5 days □ 6-9 days □ 10-14 days □ 15 or more days
6. During the past year has your child's asthma ever stopped him/her from taking part in sports, recess, physical education or other school activities?
   □ Yes □ No □ Don't know
7. How many times has your child been treated in the Emergency Department or hospitalized overnight or longer for asthma in the **past 12 months?**
   □ 0 times □ 1 time □ 2 times □ 3 times □ 4 times □ 5 or more times
8. What triggers your child's asthma or makes it worse?
   □ Smoke □ Chalk / chalk dust □ Animals / pets
   □ Mold □ Strong smells / perfume □ Grass / flowers
   □ Dust / dust mites □ Cockroaches □ Stress or emotional upsets
   □ Very hot weather □ Having a cold / respiratory illness □ Exercise, sports or playing hard
   □ Very cold weather
   (Explain_____)
   □ Foods (which ones? _____)
9. Is your child exposed to smoking? □ Yes □ No If yes, where?_____
10. What season makes your child's symptoms worse? _____
11. Does your child know how to self-administer his/her inhaler? □ Yes □ No
12. Does your child use a spacer? □ Yes □ No

**Anything else you want school staff to know:

Parent
Signature_____Date_____