Essex Regional Educational Services Commission
Asthma Questionnaire

Student name_____________________________________ Birthdate _______________________________

Parent/Guardian name_______________________________ Cell phone ______________________________

Physician's name ___________________________________Office phone _____________________________

Asthma medication ____Dose __________________

Time of day or circumstances to use medication ____

At what age did your child first have their first asthma attack?
____

How often does your child have asthma attacks?
____

How many asthma attacks has your child had in last two years?
____

Has your child been hospitalized for asthma? □ Yes □ No If yes, how often?
____

When was your child's last hospitalization for asthma?
____

Has your child used asthma medicine in the past two years? □ Yes □ No If yes, how often?
____

If you child has needed to use their asthma medicine in the past two years, we advise that your child have asthma medicine in school for asthma, to insure their health and safety. Please have your physician provide a written Asthma Action Plan and asthma medication to be used in school.

- Does your child have a wheeze or cough after exercise? □ Yes □ No
- Does your child have wheeze, chest tightness, or cough after exposure to airborne allergens or pollutants? □ Yes □ No
- Does your child cough or wheeze more than a couple times a week □ Yes □ No
- Does your child cough in their sleep more than a couple of times per month? □ Yes □ No
- Does your child miss school frequently due to asthma issues? □ Yes □ No

I understand that my child's asthma condition will be shared with school personnel on a need to know basis.

Parent/Guardian Signature____ Date_____________

Reviewing Nurse's Signature____Date______________