HEALTH SERVICES
Coopersville Area Public Schools
Asthma History Questionnaire
*This form is to be renewed annually at the beginning of each school year

Student: _____ Date of Birth: _____ Gender: _____ Grade/Teacher: _____

Emergency Contact Information		Home:	Work:	Cell:
Mom/Guardian:				
Dad/Guardian:				
Other:				
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 ☐ Cigarettes/smoke ☐ Emotions
☐ Exercise ☐ Illness ☐ Medications ☐ Chemical odors ☐ Food

How many days would you estimate he/she missed from 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 his/her 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
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.*

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 in 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. _____

Additional information:

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