Student Services Department
181 Encinal Avenue, Atherton, CA 94027
(650) 321-7140 Fax: (650) 292-2200

ASTHMA QUESTIONNAIRE

Date ________________

Check Site: ☐ Heritage Oak ☐ Laurel ☐ Encinal ☐ Oak Knoll ☐ Hillview

Please print:

Student: ____ DOB _________

Teacher: ____ Grade ________

Parent Name: ____ Email: _____________________________

Parent phone: ____ Emergency phone: _________________

School records indicate that your child has asthma. So that we can better understand the condition, please complete the questions listed below.

Was the asthma diagnosed by a physician? Yes ☐ No ☐

Child's age with first asthma episode: ____

When was doctor last consulted for this condition?____

What type of reaction does your child have? Check all that apply.

☐ Tightness in chest ☐ Shortness of breath

☐ Cough ☐ Wheezing

☐ Other (please describe): ____

____

What triggers your child's asthma?____

How frequently does this occur?____

____

What type of medication is used? 1. ________________________ 2. ________________________

3. ________________________ 4. ________________________

How frequently is medication needed?____

Would this asthma condition interfere with usual P.E. activities? Yes ☐ No ☐

If there are limitations, please describe:____

Does your child need medication at school? Yes ☐ No ☐ If yes, a *Medication Authorization Form* must be completed and returned to the school office with the medication. The Medication Authorization Form may be found on the district web site at www.district.mpcsd.org or in the school office.

Please return this completed form to the school office as soon as possible.

____ ____
Parent Signature Date

____
Print Name