MINOOKA COMMUNITY HIGH SCHOOL DISTRICT #111

ASTHMA ACTION PLAN/QUESTIONAIRE

You have indicated that your child currently has asthma. It is important to have annual health information when he/she needs medical assistance at school. Please complete this form and return to the school nurse.

Student Name ______________________ Birth Date __________ Today's Date ____________

1. How often do asthma attacks occur?______________________________
2. Has your child been treated in the hospital for asthma in the past year? ❑Yes ❑ No

   If yes, please list dates ______________________________
3. Is a peak flow meter used? ❑Yes ❑ No Best peak flow rate? ______________
4. What triggers your child's asthma attacks? **(*check all that apply*)**

   ❑ Illness ❑ Emotions ❑ Chemical Odors

   ❑ Weather ❑ Medications ❑ Foods

   ❑ Exercise ❑ Fatigue ❑ Cigarette and/or Smoke

   ❑ Other ______________________________

   ____
5. What does your child do at home to relieve wheezing during an asthma attack? **(*check all that apply*)**

   ❑ Breathing Exercises ❑ Takes Medication ❑ Inhaler

   ❑ Rest/Relaxation ❑ Nebulizer ❑ Oral Medication

   ❑ Drink Liquids (if yes please specify)______________________________

   ❑ Other ______________________________

   ____
6. Are medications needed to control asthma? ❑Yes ❑ No

   If yes, please list medications ______________________________
7. Is asthma treated by Physician? ❑Yes ❑ No

   Physician Name ______________ Office Number ______________________

   Address ____

   (Street) ***(City)*** ***(State)*** ***(Zip)***

____

Parent/Guardian (Print)

____

Parent/Guardian Signature

____

Emergency Contact Number

16-17 School Year
(Updated)