

Mokena School District 159

Student Asthma Checklist:

- Parent/Guardian fills out Questionnaire below
- Parent/Guardian and Physician complete and sign Medication Authorization Form
- Parent/Guardian turns in rescue inhaler to School Nurse

NOTE: If the student is to carry his/her inhaler on his/her person the Physician must complete and initial the Physician Authorization for Self-Administration section of the Medication Authorization Form and the Parent/Guardian must complete and sign the Authorizing Agreement for Self-Administration of Asthma Medication Form.

Parent Asthma Questionnaire

To better understand your child's Asthma, please complete the questions below.

1. When was your child diagnosed with Asthma or other Respiratory Disease requiring an inhaler? _____

2. Does your child use peak flow monitoring to manage his/her Asthma? yes no - personal best PF reading _____

3. What are your child's "triggers"? (*Check all that apply.*)

<input type="checkbox"/> illness	<input type="checkbox"/> emotions	<input type="checkbox"/> exercise/physical activity
<input type="checkbox"/> foods: (please list) _____		
Weather/Outdoor environmental:		
<input type="checkbox"/> temperature change	<input type="checkbox"/> humidity	<input type="checkbox"/> cold
<input type="checkbox"/> dry	<input type="checkbox"/> wind	<input type="checkbox"/> pollen
Indoor:		
<input type="checkbox"/> dust/dust mites	<input type="checkbox"/> mold	<input type="checkbox"/> cigarette or other smoke
<input type="checkbox"/> chemical odors (cleaners)	<input type="checkbox"/> strong odors (perfumes)	<input type="checkbox"/> animal dander (list) _____
<input type="checkbox"/> other _____		

4. Describe the symptoms your child experiences before or during an asthma episode. (*Check all that apply.*)

<input type="checkbox"/> rubbing chin/neck	<input type="checkbox"/> runny nose	<input type="checkbox"/> feeling tired/weak	<input type="checkbox"/> throat clearing
<input type="checkbox"/> tightness in chest	<input type="checkbox"/> chest pain	<input type="checkbox"/> wheezing	<input type="checkbox"/> difficulty speaking
<input type="checkbox"/> cough	<input type="checkbox"/> cough that keeps him/her awake at night		
<input type="checkbox"/> shortness of breath (breathing hard and fast) with little exertion			
<input type="checkbox"/> other _____			

5. What medications does your child use to prevent asthma flare-ups, including inhalers? _____

6. What is the treatment for your child's asthma flare-ups? _____

7. During what time of year does your child require the use of a rescue inhaler? (*Check all that apply.*)

- spring summer fall winter year round

8. How often does your child use a rescue inhaler? _____

9. Please list any other comments/concerns regarding your child's asthma: _____

Parent Signature _____ Date: _____