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

Last Updated June 18'