



South Lyon Community Schools

Special Services Office • 62500-B West Nine Mile Rd. • South Lyon, MI 48178 • (248) 573-8220 • Fax (248) 437-8438
Linda M. Raye, Director of Special Services

Parent Questionnaire Regarding Asthma

Student: _____ Brithdate: _____ Date: _____

School: _____ Teacher _____

1. Asthma Type:
2. Describe what typically happens during an asthmatic episode:
3. What triggers the asthmatic episode? What pattern is there in the time of day it occurs?
4. How long does it last?
5. Are there any warnings and/or behavior changes before the asthmatic episode?
6. Describe first aid treatment given for asthmatic episode at home.
7. Describe child's reaction to asthmatic episode.
8. What medication(s) does your child take:

Medication	Dosage	Frequency and Time of Day Taken

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9. Check any of the following school related activities that may be limited/affected by your child's asthma:

- Gym class Lunch Field Trip Sports
 Recess Transportation
 Other (Please specify) _____

Describe any limitations: _____

Physician/Clinic treating you child's asthma: _____

Physician/Clinic Address: _____

Physician/Clinic Phone: _____

Parent Signature: _____

This information expires on the last day of each school year.