Walnut Valley Unified School District

EXCELLENCE
A Commitment to the Success of All Students

880 South Lemon Avenue, Walnut, California 91789-2931 • Tel (909) 595-1261

Walnut Valley Unified School District
HEALTH SERVICES

Parent Interview of Students with Asthma

Please complete and return to school office

Student's Name _____ Grade _____ Classroom _____

The following information is helpful to your child's school nurse and school staff in determining special needs for your child. Please answer the questions to the best of your ability. If you desire a conference with the school nurse, please call for an appointment.

1. How long has your child had asthma? _____

2. Please rate the severity of his/her asthma. (circle one) {Not severe} 0 1 2 3 4 5 6 7 8 9 10 {Severe}
   a) Days of school missed each year. _____
   b) Days hospitalized. _____

3. What triggers your child's asthma attacks? (Please circle all that apply)
   Illness Emotions Medications Food Weather
   Exercise Cigarette/other smoke Chemical odors Fatigue
   Allergies/other (please list) _____

4. What does your child do at home to relieve wheezing during an asthma attack? (please circle)
   Breathing exercises Takes medicine: Inhaler__ Nebulizer__
   Rest/relaxation Drinks liquids
   Other (please describe) _____

5. Has your child been taught how to use an aero chamber, pulmonary aid, inspirease kit, or other device with his/her inhaler? (please check) Yes ☐ No ☐ Peak Flow _____

6. What medications does your child take and how often? _____
   Everyday _____
   Just for wheezing attacks _____
   Before exercise _____
   Just certain times of the year _____
   Possible side effects _____

7. Name of child's physician (for asthma): _____
   Address: _____
   Phone/Fax: _____

Last seen by physician: __/____/____