STUDENT WITH ASTHMA
Parent Questionnaire

Student's Name____ Grade_____ Homeroom____________
Parent's Name(s)____ Ph. (H)____________ (W)____________
Name of Student's Doctor (for asthma)____ Ph.____________

The following information will help your child's school nurse and school personnel meet the health needs of your child while he/she is at school. Please answer the questions to the best of your ability. If you wish to personally discuss your child's asthma with the school nurse, you may reach the school nurse at:

Nurse's Name____ Ph.________________ Days___________

1. How long has your child had asthma?____

2. How often does your child see his/her doctor for routine asthma evaluations?________________________________

3. When was his/her last appointment?____

4. During the past year how many times has your child been treated in the ER or hospitalized for asthma?
   ____

5. How many days would you estimate your child missed school last year due to asthma? _______________________

6. How many days a **week** does your child have asthma symptoms? (Circle the best choice)

   Less than 2 days/week   3-6 days/week   Daily   Continual

7. How many nights per **month** does your child have asthma symptoms?
   Less than 2 nights/month   3-4 nights/month   More than 5 nights/month   Frequent

8. How would you rate the severity of your child's asthma?

   (Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

9. How many times a month does your child use his rescue (i.e.Albuterol) inhaler?

   3 times a month or less   4-8 times per month   9 or more times per month

10. What triggers your child's asthma attacks? (Check all that apply.)
    _____ Illness   _____ Molds   _____ Exercise
    _____ Changes in temperatures   _____ Sprays/odors   _____ Fatigue
    _____ Foods   _____ Stress/emotions   _____ Animals
    _____ Chalk dust   _____ Carpets in the room   _____ Pollens

11. Is your child being treated for allergies?   Yes_____   No _____
    List known allergies ____
    ____
    ____

12. What does your child do at home to relieve wheezing? (Check all that apply.)
    _____ Breathing exercises   _____ Takes the following types of medication(s)   ____ Inhaler
    _____ Rest/relaxation   ____ Nebulizer
    _____ Drinks liquids   ____ Oral medication
    Other (please describe) ____

Continued on Page 2

13. Please list the medications your child takes for asthma and/or allergies (everyday and as needed).

Name of Medication	Dose	Frequency

14. Where do you want your child to keep his/her inhaler during the school day?
    ___ Health Office ___ With him/her

15. What, if any, side effects does your child have from his/her medication(s)? ________________________________
    ____

16. If your child does not respond to medication at school, what actions do you advise school personnel to take?
    ____
    ____

17. Does your child need any special considerations related to his/her asthma while at school? (Check all that apply and describe briefly)
    ___ Modified gym class ____
    ___ Modified recess ____
    ___ Animals in the classroom____
    ___ Avoidance of certain foods ____
    ___ Emotional or behavior concerns ____
    ___ Special considerations on field trips ____
    ___ Observation for side effects from medication _______________________________________
    ___ Other ____

18. Has your child been taught to use a spacer or other device with his/her inhaler? Yes _____ No _____

19. Has your child been taught to use a peak flow meter? Yes _____ No _____
    If yes, do you know you're your child's baseline peak flow rate is? _______________________________________

20. Has your child received asthma management education? Yes _____ No _____

21. Do you think your child holds him/herself back from participating in activities at school because of his/her asthma? Yes _____ No _____ If yes, please describe. ____
    ____

22. Does your child wear a Medic Alert bracelet or something similar to identify him/her as having asthma?
    Yes ___ No ___

23. Is there anything else you would like for school personnel to know about you child's asthma?
    ____
    ____

May this information be shared with the classroom teacher(s), bus driver(s) and other appropriate school personnel? Yes _____ No _____

____ ______________________________

Signature of Parent/Guardian Completing Questionnaire Date