Questionnaire for Parents of Child with Asthma

Student's Name _____ School Year _____
Teacher _____ Grade _____
Parent's Name (s) _____ Tel # home _____
work _____
Name of Student's Doctor (for asthma) _____ Tel # _____

The following information is helpful to your child's school nurse and school staff in determining any 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. Thank you for your time and assistance in assessing your child's special needs in school.

Nurse's Name _____ Tel # _____

1. How long has your child had asthma? _____
   Describe **symptoms** _____

2. Please rate the severity of his/her asthma. (circle)
   (Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

3. How many days would you estimate he/she missed school last year due to asthma? ___

4. What **triggers** your child's asthma attacks? (Please check any that apply.)
   ___Illness ___Emotions ___Medications ___Foods
   ___Weather ___Exercise ___Cigarette or other smoke ___Chemical odors ___Fatigue

   Allergies (please list) _____
   Other (please list) _____

5. What does your child do at home to relieve wheezing during an asthma attack?
   (Please check any that apply.)
   ___Breathing exercises
   ___Rest/relaxation
   ___Drinks/liquids
   ___Other (please describe) _____

   Takes medication: ___Inhaler ___Nebulizer ___Oral medication

6. Please list medications your child takes for asthma (everyday and as needed).

	Name of medication	Dose	Frequency
(In school)			
(At home)			

If medications are to be given during school, a medication administration authorization form is required to be completed by the physician and parent. Medications must be in the original labeled container.

7. If your child does not respond to medication, what action do you advise school personnel to take? _____
   _____

8. What, if any, side effects does your child have from his/her medications?
   _____

9. Has your child been taught how to use an extension tube, pulmonary aid, inspirease kit or other device with his/her inhaler? Yes No

10. How many times has your child been hospitalized overnight or longer for asthma in the past? (list dates) _____

11. How many times has your child been treated in the emergency room for asthma in the past year? _____

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

13. Does your child need any special considerations related to his/her asthma while at school? (Check any that apply & explain briefly. Please have physician write a note to school with details.)
    ___Modified gym class _____
    ___Modified recess outside _____
    ___No animal pets in classroom _____
    ___Avoiding certain foods _____
    ___Emotional or behavior concerns _____
    ___Special consideration while on field trips _____
    ___Special transportation to and from school _____
    ___Observation for side effects from medication _____
    ___Other _____

14. Do you know what your child's baseline peak flow rate is? Yes No
    Personal best___ Green zone___ Yellow zone___ Red zone___

15. Do you thinks your child holds him/herself back from participating in all activities at school because of his/her asthma? If so, please describe.
    _____

16. Have you ever attended an asthma education class? Yes No
    Has your child had asthma education? Yes No