QUESTIONNAIRE FOR PARENT OF CHILD WITH ASTHMA
PLEASE RETURN TO THE SCHOOL NURSE

Student's Name____ School Year_______________________

Parent's Name(s)____Telephone(H)__________(W)__________

Name of Child's Doctor (for asthma)____

1. How long has your child had asthma?____

2. Please rate asthma severity (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 attack (please check any that apply)
   ____Illness ____Emotions ____Medication ____Weather
   ____Exercise ____Cigarette or other smoke ____Foods ____Chemical Odors
   ____Other (please specifiy)____
   ____

5. What are the usual symptoms your child experiences?____
   ____

6. What does your child do at home to relieve wheezing during asthma attack? (Please check all that apply.)
   ____Breathing exercises ____Takes Medication: ____Inhaler
   ____Rest/relaxation ____Nebulizer
   ____Drink liquids ____Oral Medication
   ____Other (please specifiy)____
   ____

7. Please list of the medications your child takes for asthma (everyday and as needed)

Name of Medication Dose Frequency

(In school)____

____

(At home)____

____

8. Has your child been taught how to use an extension tube, space, pulmonary aid, inspirease kit or other devise with his/her inhaler? ____Yes ____No

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

10. How many times has your child been hospitalized overnight or longer in the past year?________________

11. Do you know what your child's best peak flow is? ____Yes ____ No Rate_______________