Parent/Guardian Asthma Questionnaire

F11

It has come to our attention that your child has asthma or breathing problems. The school nurse needs more information on your child's asthma or breathing problems. This will help us take care of your child at school. **Please complete both sides of this form.**

Child's Name _____ Grade _____ ID # _____ Date _____

Parent/Guardian _____ Home Phone Number (_____)_____

Work Number (_____)_____ Cell/Pager Phone Number (_____)_____

Where does your child receive his/her asthma care: (Name of clinic) _____

Name of Physician or Nurse Practitioner _____ Clinic Phone # _____

Name of Insurance_____. If none, do you want information on free / low cost insurance? 1_1 Yes 1_0 No

1. Please circle if your child's asthma is severe or not severe or anywhere in between (circle #) : 1 2 3 4 5
   Not severe Severe

2. How many days did your child miss school **last year** due to his/her asthma?
   ☐ 0 days ☐ 1 – 2 days ☐ 3-5 days ☐ 6-9 days ☐ 10-14 days ☐ 15 or more days

3. How many times has your child been hospitalized overnight or longer for asthma in the **past 12 months**?
   ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

4. How many times has your child been treated in the Emergency Department for asthma in the **past 12 months**?
   ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

5. What triggers your child's asthma or makes it worse?
   ☐ Smoke
   ☐ Animals / pets
   ☐ Dust / dustmites
   ☐ Cockroaches
   ☐ Grass / flowers
   ☐ Mold
   ☐ Chalk / chalk dust
   ☐ Strong smells / perfume
   ☐ Foods (which ones:_____)
   ☐ Having a cold / respiratory illness
   ☐ Stress or emotional upsets
   ☐ Changes in weather / very cold or hot air
   ☐ Exercise, sports, or playing hard

6. Does anybody in the household smoke? ☐$_1$ Yes ☐$_0$ No

7. For each season of the year, to what extent does your child usually have asthma symptoms? (Mark an X for each season below)

	A lot	A little	None
Fall	☐	☐	☐
Winter	☐	☐	☐
Spring	☐	☐	☐
Summer	☐	☐	☐

8. In the past month, during the day, how often has your child had a hard time with coughing, wheezing or breathing,?
   ☐ 2 times a week or less ☐ More than 2 times a week ☐ Every day (at least once every day) ☐ Constantly (all of the time every day)

9. In the past month, during the night, how often does your child wake up or have a hard time with coughing, wheezing or breathing,?
   ☐ 2 times a month or less ☐ More than 2 times a month ☐ More than 2 times a week ☐ Every night

10. Does your child have a written Asthma Action Plan? ☐ Yes ☐ No ☐ Don't know

11. Does your child use a peak flow meter (something he/she blows into to check his/her lungs)? ☐ Yes ☐ No ☐ Don't know

12. Do you know what your child's personal best peak flow number is? ☐ Yes → what is it? _____ ☐ No

13. Please list the medications your child takes for asthma or allergies (everyday and as needed) **or include a copy of your child's asthma action plan.**

Turn Page Over →

Medications Taken at Home

Medication Name ?	How Much?	When is it Taken ?

Medications to be Taken at School

Medication Name ?	How Much?	When Should it be Taken ?

I GIVE CONSENT FOR THE ADMINISTRATION OF THE ABOVE MEDICATIONS AT SCHOOL

parent/guardian signature _____

***I UNDERSTAND THAT I ALSO NEED SIGNED PERMISSION FROM MY CHILD'S HEALTH CARE PROVIDER TO ADMINISTER MEDICATION AT SCHOOL (a signed asthma action plan will suffice).**

Please list anything else you use for your child's asthma (tea, herbs, home remedies, etc.): _____

14. How well does your child take his/her asthma medications?

☐ Can take medicine by self ☐ Forgets to take medicine ☐ Needs help taking medicine ☐ Not using medicine now

15. Does your child usually use a spacer or holding chamber with his metered dose inhaler (a clear tube that attaches to the inhaler and better helps the inhaled medicine get into the lungs)?

☐ Yes ☐ No ☐ Don't know ☐ He/she uses a dry powdered inhaler so he/she doesn't need a spacer

16. During the past year has your child's asthma ever stopped him/her from taking part in sports, recess, physical education or other school activities?

☐ Yes ☐ No ☐ Don't know

17. Do you want to talk to the school nurse more about asthma? ☐ Yes ☐ No

If so, what is the best time to call you:? ☐ Morning ☐ Afternoon ☐ Evening

Please call the Licensed School Nurse with questions:

Nurse's name_____

Phone # _____ Pager # _____

For office use only:	Student Symptom Severity assessment:
8. _____	Mi. _____
	Mi. P. _____
9. _____	Mo.P _____
	S.P. _____

M.I. = Mild Intermittent; Mi.P. = Mild Persistent; Mo.P. = Moderate Persistent; S.P. = Severe Persistent]

Thank you for filling out this questionnaire.