LHSA

A Community Action Agency

EARLY HEAD START/HEAD START
ASTHMA PARENT QUESTIONNAIRE

Child's Name _____ Teacher _____ Room _____

Dear Parent/Guardian:

You have indicated on your child's enrollment forms, emergency card and/or health history that your child has asthma. Please complete this form and return it to school by _____.

1. Has a doctor diagnosed your child as having asthma? Yes ____ No ____

2. Has your child had symptoms of asthma in the last 12 months? Yes ____ No ____
   Symptoms of asthma include the following:
   - ✓ Coughing that won't go away
   - ✓ Wheezing that makes it hard to breathe
   - ✓ Wheezing with a cold
   - ✓ Wheezing without a cold

3. Does your child currently take medication for asthma? Yes ____ No ____
   If yes, please list all medications _____

4. Please check which of the following trigger your child's asthma.

__ animal dander	__ molds	__ respiratory infections
__ cold air	__ perfumes	__ strong odors/fumes
__ dust	__ pollen	__ tobacco smoke
__ weather changes	__ exercise	__ cockroach allergen
__ foods (list) _____		__ other

5. Does asthma prevent your child from participating in school activities? Yes ____ No ____
   If yes, please explain. _____

6. Does your child need medication at school for treatment of asthma? Yes ___ No ___

****If your child needs medical attention or medication for asthma while at school, you and your child's physician must complete and sign an ASTHMA ACTION PLAN.**

7. Is there anything else we need to know about your child's medical condition? Yes ____ No____
   _____

Parent/Guardian Signature _____Date: _____
Thank you for your cooperation.

_____ _____ _____
Early Head Start /Head Start Staff Phone # Date