SYCAMORE COMMUNITY SCHOOLS
Our students. Our future.

QUESTIONNAIRE FOR PARENTS OF A CHILD WITH ASTHMA

.

The following information is helpful to the school nurse and staff in determining any special needs for your child due to asthma. Please answer the questions to the best of your ability. If you desire a conference with the school nurse, please call the school.

Student's Name _____School Year _____

School _____ Grade _____ Classroom _____

1. How long has your child had asthma? _____
2. Rate the severity of his/her asthma.(*circle one)* (*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

   ☐ Allergies *(please list)*_____ ☐ Fatigue

   ☐ Other *(please list)* _____
5. What does your child do at home to relieve wheezing during an asthma attack? *(Please check all that apply.)*

   ☐ Breathing exercises Takes medication: ☐ Inhaler

   ☐ Rest/relaxation ☐ Nebulizer

   ☐ Drinks liquids ☐ Oral medication

   Other (*please describe)* _____
6. What medications does your child take and how often?

   Every day _____

   Just for wheezing/attacks _____

   Before exercise _____

   Just certain times of the year or when ill _____
7. What medications will your child need to take in school? Please list name of medication and when it is to be taken._____

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

   _____
9. Has your child been taught how to use a spacer 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 year? _____
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. Name of child's specialist *(for asthma).* _____

    Address_____Phone _____

14. Does your child also have allergies? _____Yes _____No If yes, please describe:_____

    _____

15. What reactions does your child have with above allergies?_____

    _____

16. Does your child need any special considerations related to his/her asthma while at school? *(Check any that apply and describe briefly.)*

    ☐ Modified gym class _____

    ☐ Modified recess outside _____

    ☐ No animal pets in classroom _____

    ☐ Avoiding certain foods _____

    ☐ Emotional or behavior concerns _____

    ☐ Special consideration while on field trips _____

    ☐ Observation for side effects from medication _____

    ☐ Need to take medication during school day (*described in question 7)* _____

    ☐ Other _____

17. If your child suffers a severe attack in school *(not relieved by medication or rest),* what plan of action would you prefer school personnel to take?_____

    _____

18. Do you know what your child's baseline peak flow rate is ☐ Yes ☐ No Rate_____

19. Do you routinely do peak flows before treating? ☐ Yes ☐ No

20. Do you think your child holds him/herself back from participating in any activities at school because of his/her asthma? ☐ Yes ☐ No

    If so, please describe. _____

21. Has child attended Camp Superkids (*a special camp for asthmatics sponsored by the American Lung Association)*? _____

22. Have you ever attended an asthma education class? ☐ Yes ☐ No

    Has your child had asthma education? ☐ Yes ☐ No

Form completed by:_____ Relationship to student_____

Thank you for your time and assisting in assessing your child's needs!