

**WOODSTOCK ACADEMY
HEALTH OFFICE
928-0413**

Questionnaire for Parents/Guardians of a Child with Asthma

Student's Name _____ Grade _____ School Year _____

Parent's/Guardian's Name(s) _____ Telephone (H) _____
(W) _____

Name of Child's Doctor (for asthma) _____ Telephone _____

The following information is helpful to your child's 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.

1. How long has your child had asthma? _____

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. In the past year:

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

Number of days with daytime asthma symptoms (wheeze, cough, chest tightness/pain, or shortness of breath) _____

Number of nights he/she woke up with asthma symptoms _____

How frequently did he/she use Quick Relief/Rescue inhaler (Albuterol, Proventil, Ventolin) _____

4. What triggers your child's asthma attacks? (Please check all that apply.)

____ Illness ____ Emotions ____ Medications ____ Weather
____ Exercise ____ Cigarette or other smoke ____ Foods ____ Chemical Odors
____ Other (please specify) _____

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

____ Breathing exercises Take Medication: ____ Inhaler
____ Rest/relaxation ____ Nebulizer
____ Drink liquids ____ Oral medication

Other (please describe) _____

6. Please list the medications your child takes for asthma (everyday and as needed). Attach sheet if necessary.

<u>Name of Medication</u>	<u>Dose</u>	<u>Frequency</u>
(In school) _____	_____	_____

(At home) _____	_____	_____
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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, spacer, pulmonary aid, inspirease kit or other device with his/her inhaler? _____ Yes _____ No
Which device does your child usually use? _____
10. How many times has your child been treated in the emergency room for asthma in the past year? _____
11. How many times has your child been hospitalized overnight or longer 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 and describe briefly)
Modified gym class _____
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 best peak flow rate is? Yes _____ No _____ Rate _____
15. Do you think your child holds him/herself back from participating in any activities at school because of his/her asthma? If so, please describe _____

Thank you for your time and assistance in assessing your child's special needs in school.

Parent Signature _____ Date _____

School Nurse Signature _____ Date _____