Parent/Guardian Asthma Questionnaire

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? 1₁ Yes 1₀ 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 ?

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

Medications to be Taken at School

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

☐ 14. 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

☐ 15. 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

16. 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.