Questionnaire for Parents/Guardian of a Child with Asthma

Date_____

Student's Name_____ Birth date_____

School_____Grade_____ Teacher/Homeroom_____

Parent/Guardian_____ Phone (home) _____

Address_____ Phone (work)_____

Parent/Guardian_____ Phone (home)_____

Address_____ Phone (work)_____

Emergency Contact_____ Phone_____

Primary Health Care Provider_____ Phone_____

The following is helpful to your child's nurse and 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.

School Nurse_____ Telephone_____

1. How long has your child had asthma?_____
2. Please rate the severity of the asthma. (circle one)

   (not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)

3. How many school days would you estimate (s)he missed due to asthma last year? _____
4. How many times has this child been seen in the emergency room for asthma in the past year?_____

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

- o Exercise
- o Illness
- o Allergies
- o Animals
- o Temperature changes
- o Strong odors or fumes
- o Stress
- o Foods
- o Fatigue
- o Other (please list)

_____
_____
_____

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

- o Takes medication ____inhaler _____nebulizer ____ oral medication
- o Breathing exercises
- o Rest/relaxation
- o Drinks liquids
- o Other (please describe)

_____
_____

7. What medication does this child take for asthma (every day and as needed):

Medication Name	Amount	Delivery Method (nebulizer, inhaler)	How Often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What herbal remedies, if any, does this student take for asthma?

_____

8. Will your child need to take medication at school? _____yes _____no

Please list name and type:

_____

_____

_____

9. What, if any, side effects does your child have from the medication(s)?

_____

10. Does this child use any of the following aids for managing asthma?

- o Holding chamber
- o Holding chamber w/mask
- o Spacer
- o Peak flow meter

11. Does your child have any special considerations related to asthma while at school?
(check any that apply and describe if needed)

- o Need to take medication during the school day
- o Modified gym class
- o Modified recess
- o Emotional or behavior concerns
- o No animals/pets in the classroom
- o Avoid certain foods
- o Special concerns while on field trips
- o Observation for side effects from medication
- o Other _____
_____

Describe needs:

_____

_____

12. Has this student had asthma education? _____yes _____no

13. Would you like asthma education for _____child _____self

Please feel free to write in any other information you feel is important to share. Thank you for your time and assistance in assessing your child's very special needs in school. Please return this form to the school nurse as soon as possible.

Parent Signature:_____

Nurse's Signature:_____

Received (date):_____

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