STUDENT WITH ASTHMA
Parent Questionnaire

Student’s Name_________________________________________ Grade_____ Homeroom____________
Parent’s Name(s)________________________________________ Ph. (H)____________ (W)____________
Name of Student’s Doctor (for asthma)_________________________________________ Ph.____________

The following information will help your child’s school nurse and school personnel meet the health needs of your child while he/she is at school. Please answer the questions to the best of your ability. If you wish to personally discuss your child’s asthma with the school nurse, you may reach the school nurse at:

Nurse’s Name__________________________________________ Ph._______________ Days___________

1. How long has your child had asthma?_____________________________________________________________

2. How often does your child see his/her doctor for routine asthma evaluations?______________________________

3. When was his/her last appointment?_______________________________________________________________

4. During the past year how many times has your child been treated in the ER or hospitalized for asthma?

5. How many days would you estimate your child missed school last year due to asthma? ______________________

6. How many days a week does your child have asthma symptoms? (Circle the best choice)

   Less than 2 days/week  3-6 days/week  Daily  Continual

7. How many nights per month does your child have asthma symptoms?

   Less than 2 nights/month  3-4 nights/month More than 5 nights/month Frequent

8. How would you rate the severity of your child’s asthma?

   (Not Severe) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

9. How many times a month does your child use his rescue (i.e. Albuterol) inhaler?

   3 times a month or less  4-8 times per month  9 or more times per month

10. What triggers your child’s asthma attacks? (Check all that apply.)

    Illness  Molds  Exercise
    Changes in temperatures  Sprays/odors  Fatigue
    Foods  Stress/emotions  Animals
    Chalk dust  Carpets in the room  Pollens

11. Is your child being treated for allergies? Yes_____ No _____

    List known allergies ________________________________________________________________

12. What does your child do at home to relieve wheezing? (Check all that apply.)

    Breathing exercises  Takes the following types of medication(s)  Inhaler
    Rest/relaxation  Nebulizer
    Drinks liquids  Oral medication
    Other (please describe) ________________________________________________________________

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13. Please list the medications your child takes for asthma and/or allergies (everyday and as needed).

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<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>Frequency</th>
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14. Where do you want your child to keep his/her inhaler during the school day?
   ___ Health Office   ___ With him/her

15. What, if any, side effects does your child have from his/her medication(s)?
   ______________________________
   ___________________________________________________________________________

16. If your child does not respond to medication at school, what actions do you advise school personnel to take?
   ___________________________________________________________________________
   ___________________________________________________________________________

17. Does your child need any special considerations related to his/her asthma while at school? (Check all that apply and describe briefly)
   ___ Modified gym class
   ___ Modified recess
   ___ Animals in the classroom
   ___ Avoidance of certain foods
   ___ Emotional or behavior concerns
   ___ Special considerations on field trips
   ___ Observation for side effects from medication
   ___ Other

18. Has your child been taught to use a spacer or other device with his/her inhaler?   Yes _____ No _____

19. Has your child been taught to use a peak flow meter?    Yes _____ No _____
   If yes, do you know your child’s baseline peak flow rate is? ____________________

20. Has your child received asthma management education?    Yes _____ No _____

21. Do you think your child holds him/herself back from participating in activities at school because of his/her asthma?    Yes _____ No _____
   If yes, please describe. _______________________________________________________

22. Does your child wear a Medic Alert bracelet or something similar to identify him/her as having asthma?    Yes ___  No ___

23. Is there anything else you would like for school personnel to know about your child’s asthma?
   ___________________________________________________________________________
   ___________________________________________________________________________

May this information be shared with the classroom teacher(s), bus driver(s) and other appropriate school personnel?    Yes _____ No _____

Signature of Parent/Guardian Completing Questionnaire ____________________________ Date ____________________________

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