

Questionnaire For Parent of a Child With Asthma

Student Name: _____ Date _____ Grade _____ Teacher _____

Parents Names: _____ Telephone(Home) _____ (Work) _____
_____ (Home) _____ (Work) _____

Physician Name: _____ Telephone _____

Asthma/Respiratory Physician Name: _____ Telephone _____

The following information is helpful to school staff in determining any special needs for your child. Please answer the questions to the best of your ability. Please contact the school nurse should you have any further information, which will help in meeting your child's needs.

1. How long has your child had asthma? _____
2. _____ 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. Is your child absent from school often due to asthma? _____
4. What triggers your child's asthma attacks? (Please check any that apply)
 Illness Emotions Medication
 Foods Weather Exercise
 Cigarette/Smoke Chemical Odors
 Allergies (please list) _____
 Other _____
5. What does your child do at home to relieve a wheezing attack? (Check all that apply)
 Breathing Exercises
 Rest/Relaxation
 Drinks/Liquid
 Takes Medication: Inhaler (name) _____
 Nebulizer (name) _____
 Oral Medications (name) _____

6. What Medication does your child take and how often?
Every day _____
Before exercise _____

During allergy season _____
When ill _____

7. What medication will your child need to take in school? (Name and times to be given)

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

9. How many times has your child been treated in the Emergency Room for asthma in the past year? _____
10. How many times has your child been hospitalized overnight or longer in the past year? _____
11. How often does your child see his/her doctor for routine asthma evaluations? _____
12. Does your child need any of the following special considerations related to his/her asthma while at school? (Check any that apply and describe briefly.)
____ Modified gym class _____
____ Modified recess _____
____ No animal or pets in classroom _____
____ Avoiding certain foods _____
____ Emotional or behavioral concerns _____
____ Special considerations while on field trips _____
____ Other _____
13. If your child suffers a severe asthma episode in school (not relieved by medication and rest), what plan of action would you want school personnel to take. _____

14. Do you know what your child's baseline peak flow rate is? Yes ___ Rate ___ No ___
15. Does your child restrict him/herself from any activities due to asthma,? ___ If yes, please explain. _____
16. Has your child participated in asthma education? Yes ___ No ___
Did you also participate in this education? Yes ___ No ___