



Questionnaire for Parents of a Child with Asthma

Date: _____

Name: _____

DOB: _____

Student ID # _____

Campus: _____

Grade: _____

Dear Parent/Guardian:

The following information is helpful to your child's school 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.

Nurse's Name _____ Telephone Number _____

1. How long has your child had asthma? _____

2. Please rate the severity of his/her asthma? _____

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

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

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

- Illness Emotions Medications Foods
- Weather Exercise Cigarette or Chemical odors
- Other smoke Fatigue

Allergies (please list) _____

Other (please list) _____

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

- Breathing exercises Takes medication: Inhaler
- Rest/relaxation Nebulizer
- Drinks liquids Oral medication

Other (please describe) _____

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

Name of Medication _____ Dose _____ Frequency _____

(In School) _____

(At Home) _____

If medications are to be given during school, a medication permission slip needs to be filled out yearly. Medications must be in the original labeled container. (When you get prescriptions filled you can ask the pharmacist to put them into two containers so you'll have one for school and one for home use.)

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?



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9. Has your child been taught how to use an extension tube, pulmonary aid, inspirease kit or other device with his/her inhaler? Yes No

10. How many times has your child been hospitalized overnight or longer for asthma in the past year?

11. How many times has your child been treated in the emergency room for asthma 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 _____
- Modified recess outside _____
- No animal pets in classroom _____
- 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 baseline peak flow rate is? Yes No Rate _____

15. Do you think your child holds him/herself back from participating in all activities at school because of his/her asthma? If so, please describe. _____

16. Have you ever attended an asthma education class? Yes No

17. Has your child had asthma education? Yes No

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