QUESTIONNAIRE FOR PARENTS OF CHILD WITH ASTHMA

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School year \_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

1. When was your child diagnosed with asthma? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please rate the severity of his/her asthma (circle)

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

1. How many days would you estimate he/she missed school last year due to asthma? \_\_\_\_\_\_\_\_\_
2. What triggers your child’s asthma attacks? (Please check all that apply.)

\_\_\_\_\_ Illness \_\_\_\_\_\_ Emotions \_\_\_\_\_ Medications \_\_\_\_\_ Foods

\_\_\_\_\_ Weather \_\_\_\_\_\_ Exercise \_\_\_\_\_Cigarette or \_\_\_\_\_ Chemical odors

\_\_\_\_\_ Fatigue \_\_\_\_\_\_ Scents other smoke

Allergies (Please List) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_Breathing exercises Takes medication \_\_\_\_\_ Inhaler

\_\_\_\_\_Rest/relaxation \_\_\_\_\_ Nebulizer

\_\_\_\_\_Drinks liquids \_\_\_\_\_ Oral medication

\_\_\_\_\_Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name of medicine Dose Frequency

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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If medications are to be given during school, a medication permission form needs to be completed yearly. Medications must be in the original labeled container.

Nurse: Leigh Kelly , BSN, RN SCE School Nurse Phone: 936-276-3509