QUESTIONNAIRE FOR PARENT/GUARDIAN OF CHILD WITH ASTHMA

The following information will be 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 and return this form to the school nurse. If you desire a conference with the school nurse, please call for an appointment.

Student Information

Student Name:	Date Of Birth:	Grade:	Homeroom:
Health Care Provider Name:	Clinic:	Phone:	
Parent/Guardian Name:	Home:	Work:	Cell:
Parent/Guardian Name:	Home:	Work:	Cell:

Allergies (food, medication, etc.):

Name of Preferred Hospital if transport via ambulance is necessary:

Asthma Information

When was your child diagnosed with asthma? By whom?

What symptoms does your child have with an asthma attack?

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

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

- ☐ Illness
- ☐ Weather
- ☐ Chemical Odors
- ☐ Emotions
- ☐ Exercise
- ☐ Medications, specify:
- ☐ Fatigue
- ☐ Cigarette or Other Smoke
- ☐ Food, specify:
- ☐ Other:

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

- ☐ Breathing exercise
- ☐ Rest/ Relaxation
- ☐ Distraction
- ☐ Inhaler
- ☐ Nebulizer
- ☐ Other:

Please list the medication(s) your child takes for asthma (daily, prior to activity, or as needed)*

Name of Medication(s)/ How much/ How often

IF MEDICATION IS TO BE GIVEN DURING SCHOOL HOURS, A ***MEDICATION CONSENT FORM MUST BE COMPLETED AND SIGNED BY ***PARENT/GUARDIAN AND LICENSED HEALTHCARE PROVIDER***. MEDICATION MUST BE IN THE ORIGINAL LABELED CONTAINER WHEN DELIVERED TO SCHOOL. MECATION CONSENT FORMS ARE AVAILABLE IN THE NURSE'S OFFICE AND MUST BE RENEWED EACH SCHOOL YEAR.*

Does your child experience any side effects from his/her medication? _No _Yes

If yes, please describe:

Is a spacer used with your child's inhaler? _No _Yes

Has your child been taught by his/her health care provider on how to use his/her inhaler and/or nebulizer? _No _Yes

Has your child been taught how to use an extension tube, spacer, pulmonary aid or other device with his/her inhaler? _No _Yes

If yes, what device is used?

Is your child able to correctly self-administer his/her asthma medication? _No _Yes

When was your child's last asthma attack?

How many times has your child been treated in the Emergency Department or Urgent Care for asthma in the past year*? [Please provide date(s)]*

How many times has your child been hospitalized overnight or longer in the past year? *[Please provide date(s)]*

How often does your child see his/her doctor for routine asthma evaluation?

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 animals/ pets in classroom

  _____

- ☐ Avoid certain foods

  _____

- ☐ Emotional or behavior concerns

  _____

- ☐ Special consideration while on field trips

  _____

- ☐ Special transportation to and from school

  _____

- ☐ Observation for side effects from medications

  _____

- ☐ Other

  _____

What is your child's personal best peak flow rate? *(If known)*

Does your child know how to use a peak flow meter? _No _Yes _Not Applicable

Do you think your child holds him/herself back from participating in activities at school because of his/her asthma? _No _Yes If yes, please describe:
Has your child ever attended an asthma education class? _ No _ Yes
Is there any additional information we should have to better manage your child's asthma?
HOME ENVIRONMENT
Is your child around anyone who smokes at home? _No _Yes
Do you have carpet in the house? _No _Yes
Does your family own any pets? _No _Yes If yes, specify type and whether living indoors or outdoors
How does your child and family feel about your child's asthma?

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

School:	
School Health Counselor(Nurse):	Phone: