

"Your" School Health Office Parent/Guardian Asthma Questionnaire

Today's Date _____ Child's Name _____ Age _____ Grade _____

Parent/Guardian _____ Home Phone _____

Work Phone _____ Cell Phone _____

Where does your child receive his/her asthma care? _____

1. On a scale of 1-5 please rate the severity of your child's asthma: 1= not severe and 5 = severe
1=not severe 2 3=in between 4 5=severe
2. How many days did your child miss school during the last school year due to his/her asthma?
0 times 1-2 days 3-5 days 6-9 days 10-14 days 15 or more days
3. How many times has your child been hospitalized overnight for asthma in the past 12 months?
0 times 1 time 2 times 3 times 4 times 5 or more times
4. How many times has your child been treated in the emergency department for asthma in the past year?
0 times 1 time 2 times 3 times 4 times 5 or more times
5. What triggers your child's asthma or makes it worse? (please circle)
pollens air pollution changes in weather
mold chalk dust foods
animal/pets strong odors stress/emotions
dust exercise/sports chemicals
cigarette smoke virus/cold symptoms other _____
6. For which season of the year does your child usually have asthma symptoms?
Fall Winter Spring Summer All months
7. In the past month, during the day, how often has your child had coughing/wheezing or breathing difficulties?
Less than 2 X's week 2 X's week More than 2 X's week Everyday (at least once a day)
8. In the past month, during the night, how often has your child awakened or had coughing, wheezing, or breathing difficulties?
Less than 2 X's month More than 2 X's month More than 2 X's week Everynight
9. How many times do you refill your child's prescription for quick-relief inhalers each year? _____
10. Does your child have a written Asthma Action Plan? Yes No Unsure
11. Does your child use a spacer when taking his/her inhaler? Yes No
12. Does your child use a peak flow meter? (a device he/she blows into to check his/her airway)
Yes No Unsure
13. Do you know what your child's personal best peak flow number is? _____

14. Please list the medications your child takes for asthma or allergies (every day and as needed)

Medication Name	Frequency	What time of day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. How well does your child take his/her asthma medications?

Independent needs assistance often forgets currently not using medication

16. During the past year, how frequently has your child's asthma stopped him/her from taking part in sports, recess, physical education, or other activities?

Never Once in a while Fairly often Frequently

Thank you for taking the time to fill out this form,

School Nurse