**Ages 5-11 Parent/Guardian Asthma Questionnaire-Control**

Please complete this form and return it to the school health office. The school nurse needs more information about your child's asthma or breathing problems. This will help us take care of your child at school.

Date:

| Student Name: |
| --- |
| Grade: |
| ID Number: |
| Birth Date: |
| Parent/Guardian: |
| Relationship to Student: |
| Home Phone: Work Phone: Cell Phone:  |
| Name of clinic where your child receives their asthma care: |
| Name of Physician or Nurse Practitioner: |
| Clinic Phone: |
| Name of Insurance: |
| If none, do you want information on free or low cost insurance? [ ] Yes or [ ] No |
| 1. How old was your child when they were diagnosed with asthma or breathing problems?
 |
| 1. How many days did your child miss school last year due to their asthma/breathing problems?[ ] 0 days [ ] 1-2 days [ ] 3-5 days [ ] 6-9 days [ ] 10-14 days [ ] 15 days or more
 |
| 1. How many times has your child been hospitalized overnight or longer for asthma/breathing problems in the **past 12 months?**[ ] 0 times [ ] 1 time [ ] 2 times [ ] 3 times [ ] 4 times [ ] 5 or more times
 |
| 1. How many times has your child been treated in the Emergency Department for asthma/breathing problems in the **past 12 months?**[ ] 0 times [ ] 1 time [ ] 2 times [ ] 3 times [ ] 4 times [ ] 5 or more times
 |

| 1. What triggers your child’s asthma or makes it worse?[ ] Smoke-tobacco, wood, any type

[ ] Animals, pets[ ] Dust, dust mites[ ] Cockroaches[ ] Grass, flowers[ ] Mold[ ] White board markers[ ] Chalk, chalk dust[ ] Strong smells, perfumes, lotions, cleaning products[ ] Having a cold, respiratory illness[ ] Stress or emotional upsets[ ] Changes in weather, very cold or hot air[ ] Exercise, sports, or playing hard[ ] Foods (which ones): [ ] Other:  |
| --- |
| 1. Does anybody in the household smoke?[ ] Yes[ ] No
 |
| 1. For each season of the year, to what extent does your child usually have asthma symptoms?

(Mark each season below):Fall: [ ] A lot [ ] A little [ ] NoneWinter: [ ] A lot [ ] A little [ ] NoneSpring: [ ] A lot [ ] A little [ ] NoneSummer: [ ] A lot [ ] A little [ ] None |
| 1. In the past month, during the **day**, how often has your child had a hard time with symptoms (coughing, wheezing or breathing)?

[ ] 2 days a week or less but not more than once on each day[ ] More than 2 days a week or multiple times on 2 or less days per week[ ] Throughout the day every day |
| 1. In the past month, during the **night**, how often has your child had a hard time with coughing, wheezing and breathing?[ ] Less than or equal to 1 time a month

[ ] Greater than or equal to 2 times a month[ ] Greater than or equal to 2 times a week |
| 1. Rescue/reliever inhaler use for symptoms (not for prevention of exercise induced symptoms). [ ] 2 days a week or less

[ ] Greater than 2 days a week but not daily[ ] Several times a day |
| 1. Has asthma made it hard for your child to do normal every day activities?[ ] No[ ] Sometimes[ ] Most of the time
 |

| 1. Has your child had an asthma attack requiring them to have to take steroids (ex. Prednisone) by mouth? [ ] No[ ] Sometimes[ ] Most of the time
 |
| --- |
| 1. Does your child have a written Asthma Action Plan? [ ] Yes[ ] No[ ] Don’t know
 |
| 1. Does your child use a peak flow meter (something he/she blows into to check his/her lungs)? [ ] Yes[ ] No[ ] Don’t know
 |
| 1. Do you know what your child’s personal best peak flow number is? [ ] Yes, if yes, what is it?[ ] No
 |
| 1. Please list the medications your child takes for asthma or allergies (every day and as needed) or **include a copy of your child’s Asthma Action Plan**.
 |
| Medications your child takes **at home**: Medication Name: How Much? When is it taken?  |
| Medications your child takes **at school**: Medication Name: How Much? When is it taken?  |
| **I GIVE CONSENT FOR THE MEDICATIONS LISTED ABOVE TO BE GIVEN TO MY CHILD AT SCHOOL**Parent / guardian signature: |
| **\*I UNDERSTAND THAT I ALSO NEED SIGNED PERMISSION FROM MY CHILD’S HEALTH CARE PROVIDER FOR MEDICATIONS TO BE GIVEN AT SCHOOL (A signed Asthma Action Plan will suffice).** |
| Please list anything else you use for your child’s asthma (tea, herbs, home remedies, etc.) |
| 1. What are your child’s usual symptoms of an asthma episode?

[ ] Wheezing[ ] Itchy throat[ ] Chest tightness[ ] Shortness of breath[ ] Coughing[ ] Waking up at night[ ] Difficulty breathing[ ] Irritable/crabby[ ] Stomach ache[ ] Other: |

| 1. Has your child had an asthma attack requiring them to take steroids (ex. Prednisone) by mouth?

[ ] Yes[ ] No[ ] Don’t know |
| --- |
| 1. How well does your child take their asthma medications?[ ] Can take medicine by self

[ ] Forgets to take medicine[ ] Needs help taking medicine[ ] Not using medicine now |
| 1. Does your child usually use a spacer or holding chamber with his/her metered dose inhaler?(a clear tube attached to the inhaler that helps the inhaled medicine get into the lungs)

[ ] Yes[ ] No[ ] Don’t know[ ] He/she uses a dry powdered inhaler so they don’t need a spacer |
| 1. During the past year has your child ever stopped taking part in sports, recess, physical education or other school activities? [ ] Yes[ ] No[ ] Don’t know
 |
| 1. Do you want to talk to the school nurse more about asthma? [ ] Yes[ ] NoIf so, what is the best time to call you?[ ] Morning[ ] Afternoon[ ] Evening
 |
| **Please call the Licensed School Nurse with questions:**Nurses name: Phone number: Pager number:  |

| **For office use only: Student Symptom CONTROL Assessment:** |
| --- |
| 8. |
| 9. |
| 10. |
| 11. |
| 12. |
| Well Controlled (WC); Not Well Controlled (NWC); Very Poorly Controlled (VPC) |