**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: |
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| 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 None Winter: A lot A little None Spring: A lot A little None Summer: 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 No If 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:** |
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| 8. |
| 9. |
| 10. |
| 11. |
| 12. |
| Well Controlled (WC); Not Well Controlled (NWC); Very Poorly Controlled (VPC) |