Questionnaire for Parents of Children with Asthma

Student's Name:_____ School Year:_____

School:_____Grade:_____Teacher:_____

Name of child's doctor (for Asthma):_____

Name of Clinic:_____Phone:_____

How long has your child had Asthma?_____

Please rate the severity of his/her Asthma (circle)

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

What triggers your child's Asthma attacks? (circle all that apply)

Illness Emotions Medication Cigarette or other smoke

Food Weather Exercise Chemical odors Fatigue

Allergies (please list):_____
Other (please list):_____

What does your child do at home to relieve wheezing during an Asthma attack? (circle all that apply)

Breathing exercise Rest/Relaxation Drink Fluids

Inhaler Nebulizer Oral Medications

Other (please describe):_____

Please list the medications your child takes for Asthma and mark if they are administered at school, home or both.

Name of Medication Dose Frequency Taken at School, Home, or Both

_____

_____

_____

If your child does not respond to medication, what action do you advise the school personnel to take?

_____

_____

_____

What, if any, side effects does your child have from the medications?

_____

_____

_____

Additional information/Comments:

_____

_____

_____

Any questions or concerns please contact Maria School Nurse, 320-384-6443 (HES), 320-384-6132 (HFHS), 320-233-7611 (FES)