

Saint Thomas Academy Parent/Guardian Asthma Questionnaire

It has come to our attention that your child has asthma or breathing problems. The school nurse needs more information on your child's asthma or breathing problems. This will help us take care of your child at school. **Please complete both pages of this form.**

Child's Name _____ Grade _____ Date _____

Parent/Guardian _____ Home Phone Number () _____

Work Number () _____ Cell/Pager Phone Number () _____

Where does your child receive his/her asthma care: (Name of Clinic) _____

Name of Physician or Nurse Practitioner _____ Clinic Phone # _____

Name of Insurance _____ If none, do you want information on free/low insurance? _____

1. Please rate how severe you feel your child's asthma is: 1 2 3 4 5
Not Severe Severe

2. **Last year**, how many days of school did your child miss due to his/her asthma?

- 0 days 1 - 2 days 3-5 days 6-9 days 10-14 days 15 or more days

3. **In the past 12 months**, how many times has your child been hospitalized overnight or longer for asthma?

- 0 days 1 - 2 days 3-5 days 6-9 days 10-14 days 15 or more days

4. **In the past 12 months**, how many times has your child been treated in the Emergency Department for asthma?

- 0 days 1 - 2 days 3-5 days 6-9 days 10-14 days 15 or more days

5. What triggers your child's asthma attacks?

- | | | |
|-----------------------------------------|------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Smoke | <input type="checkbox"/> Having a cold/respiratory illness | <input type="checkbox"/> Mold |
| <input type="checkbox"/> Animals/Pets | <input type="checkbox"/> Stress or emotional upsets | <input type="checkbox"/> Exercise, sports, playing hard |
| <input type="checkbox"/> Dust/Dustmites | <input type="checkbox"/> Changes in weather/very cold or hot air | <input type="checkbox"/> Chalk/Chalkdust |
| <input type="checkbox"/> Cockroaches | <input type="checkbox"/> Strong smells/perfume | <input type="checkbox"/> Other |
| <input type="checkbox"/> Grass/Flowers | <input type="checkbox"/> Foods (which ones) | |

6. Does anybody in the household smoke? Yes No

7. For each season of the year, to what extent does your child usually have asthma symptoms?

(Mark an X for each season below)

	A lot	A little	None
Fall			
Winter			
Spring			
Summer			

Please list anything else you use for your child's asthma (tea, herbs, home remedies, etc.):

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

- | | |
|-----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Can take medicine by self | <input type="checkbox"/> Forgets to take medicine |
| <input type="checkbox"/> Needs help taking medicine | <input type="checkbox"/> Not using medicine now |

15 Does your child usually use a spacer or holding chamber with his inhaler? Yes No Don't know

- He uses a dry powered inhaler so he doesn't need a spacer

16. During the past year has your child's asthma ever stopped him from taking part in sports, recess, physical education or other school activities? Yes No Don't know

17 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:

Nurse's Name _____

Phone # _____

Pager # _____