Parent/Guardian Asthma Questionnaire – Roseville Area Schools

It has come to our attention that your child has asthma or reactive airway. Completing this form will help us take care of your child's health at school.

Child's name ______________________________ Grade ________

Doctor / Clinic treating asthma: ______________________________ Phone: ______________

If access to healthcare for your child is a problem, please call the school nurse

1. How do you rate your child's asthma?

Severity	**Mild intermittent**	**Mild Persistent**	**Moderate Persistent**	**Severe Persistent**	☐ **Other** (describe below)
Daytime Symptoms	☐ 2 days a week or less	☐ 2 times a week but less than once a day	☐ Symptoms daily	☐ Continuous daily symptoms	
Nighttime symptoms	☐ 2 nights a month or less	☐ less than 2 nights a month	☐ less than one night a week	☐ Frequent nighttime symptoms	

2. What triggers your child's asthma or makes it worse?

☐ Smoke
☐ Animals/pets
☐ Dust/dust mites
☐ Mold
☐ Grass/flowers
☐ Chalk/chalk dust
☐ Strong smells/perfume
☐ Stress/emotional upset
☐ Exercise, sports, playing hard
☐ Having a cold/respiratory illness
☐ Changes in weather/ very cold or hot air
☐ Other (list) : ______________________________

3. If symptoms are seasonal, which seasons cause asthma? ☐ Spring ☐ Summer ☐ Fall ☐ Winter

4. Does your child use a peak flow meter ?
☐ Yes ☐ No ☐ Don't know

5. Does your child usually use a spacer or holding chamber with his metered does inhaler ?
☐ Yes ☐ No ☐ Don't know ☐ My child uses a dry powdered inhaler so doesn't need a spacer

6. My child's asthma requires medication ☐ daily all year ☐ intermittently as needed

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

8. Health care provider recommends my child self-carry his/her own inhaler: ☐ Yes ☐ No
Parent recommends child self-carry his/her own inhaler: ☐ Yes ☐ No

** Prior to self-carrying at school, student's ability must be assessed by the school nurse and the Asthma Management Assessment Tool worksheet must be completed.*

9. If interested in self-carrying, check the following:
My child may attend a self-carrying assessment small group class. ☐ Yes ☐ No

Please call the Health Office with questions:

Nurse's name: ______________________ Phone: ______________ Fax: ____________

Parent/Guardian Signature: ______________________________ Date: ____________

Revised March 2007