CREC | Schools of Excellence

DISCOVERY ACADEMY

Asthma Questionnaire for Parents

Child's Name_____ Grade_____

Parent's Name_____

Name of Doctor treating asthma_____

Name of Clinic_____ Clinic Phone_____

1. At what age was your child's asthma diagnosed? _____
2. How severe is your child's asthma?
   ☐mild ☐moderate ☐severe
3. What are your child's usual signs/symptoms during as asthma attack?
   ☐wheezing ☐cough ☐difficulty breathing
   ☐chest tightness ☐anxiety ☐other_____
4. How many days of school would you estimate your child missed last year due to asthma? _____
5. In the past year, how many times has your child been treated in the emergency room for asthma symptoms? _____
6. In the past year, how many times has your child been hospitalized (overnight or longer) for asthma symptoms? _____
7. In the past month, during the day, how often has your child had asthma symptoms? _____
8. In the past month, during the night, how often does your child wake up or experience asthma symptoms?_____
9. What triggers your child's asthma symptoms?
   ☐exercise ☐stress ☐cold air ☐illness
   ☐allergies to _____
   ☐smoke (Does anyone smoke at home?_____)
   ☐other_____

Please complete back side also!

10. What does your child do at home to relieve the symptoms during an attack?

☐rests ☐drinks fluids ☐uses breathing exercises

☐takes medication

☐other_____

11. Does your child have an Asthma Action Plan (a written treatment plan created by your doctor and specific to your child)? If yes, please include a copy.

☐yes ☐no ☐don't know

A blank Asthma Action Plan is included with this questionnaire. Please complete it with your child's doctor and return to school with any medication that may be needed while at school

12. What medications is your child using presently to control or treat asthma symptoms? (Sometimes or all the time)

Name of medication	How much?	How often?