SOMERDALE PARK SCHOOL

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PARENT QUESTIONAIRE FOR STUDENTS WITH ASTHMA

Student's Name :_____ **Date of Birth:**_____
Grade:_____ **Teacher:**_____ **School Year:** _____

Physician:_____ **Phone# :** _____
Physican's Address:_____ **Asthma Allergy Specialist Yes:**___ **No:**__

Parent/Guardian(s) Names: _____
Mother Day Phone#:_____ **Father Day Phone#:** _____
Guardian Day Phone# :_____ **Home Phone#:** _____

Known Allergies/Triggers:
Foods:
Environmental Triggers:
Medications:

1. **How long has your child had asthma?:**_____
2. **Please rate the severity of your child's asthma: (circle please)**
   (not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)
3. **Indicate how frequently he/she has asthma symptoms that require intervention:**
   Daily:_____ **Weekly:**_____ **Monthly:**_____ **Seasonally:**_____ **When Sick:**_____
4. **How many days would you estimate he/she missed school last year due to asthma symptoms?** _____
5. **What Triggers your child's asthma symptoms: (please check all that apply)**
   _____ Illness _____Emotions _____ Chemical odors ____Weather
   _____Exercise _____Medications _____ Foods ____Fatigue
   _____Cigarette or other smoke _____ Seasonal Allergies
   _____Other (Please List):_____
6. **What does your child do at home to relieve wheezing during an asthma attack?**
   ____Breathing exercises ____Rest/relaxation ____Drink liquids
   ____Take Medications: ___Inhalers ___Nebulizer Treatments ____Oral Medications
   ___ Other (Please List) : _____
7. **What medications does you child take & how often:**
   Everyday:_____
   Just as needed for wheezing/other symptoms i.e.: coughing /Shortness of breath:
   _____
   Before Exercise:_____
   Just certain times of the year or when ill:
   _____

-Over-

8. **What Medications will you child need to take in school:**

   _____

   _____

   _____

Please Note: When any **PRESCRIPTION MEDICATION** needs to be given during school hours, your child's physician must send a prescription to the school nurse indicating the date, student's name, name of medication, dosage of medication, length of time for prescription to be administered, purpose of medication, the time or special circumstances under which the medication shall be administered, and any possible side effects. **ABSOLUTELY NO PRESCRIPTION MEDICATION WILL BE ADMINISTERED WITHOUT A PHYSICAN'S PRESCRIPTION THAT INCLUDES THE ABOVE CRITERIA; THE PRESCRIPTION MUST EITHER BE ON A BLUE LEGAL PRECRIPTION FORM OR An Asthma Treatment Plan (preferred) FORM AVAILABLE FROM THE SCHOOL NURSE OR on THE SCHOOL'S WEBSITE**.

9. **Who is responsible for remembering to administer medications at home:**
   ___Parent(s) ___Child ____Both

10. **What if any side affects does your child have to his/her medications:**

    _____

    _____

11. **Has you child been taught how to use an extension tube/spacer with his/her inhaler?**
    ____yes ___No

12. **How many times, has your child, been hospitalized overnight or longer for asthma symptoms in the last year? : _____**

13. **How often does your child see his/her Doctor for routine asthma evaluations? :**
    Every 3 months:____ Every 6 months: ____ Every 12 months: _____ Other:_____

14. **Does your child need any special considerations related to his/her asthma while at school: (check all that apply & describe briefly)**
    ___Modified Physical Education Class: _____
    ___Modified Outside Recess :_____
    ___Limited/No exposure to animals/pets in classroom:_____
    ___Avoidance of certain foods:_____
    ___Emotional/Behavioral concerns:_____
    ___Special considerations for field trips:_____
    ___Observation for adverse effects to medications:_____
    ___Access to Inhaler (Carrying of & Self-Administration for gr6-8 only): _____
    ___Other: _____

15. **Do you know what your child's baseline peak flow rate is? :Yes_____ Rate = _____ No_____**

16. **Do you & your child's Physician use an Asthma Treatment Plan to provide planned intervention for your child's asthma symptoms? (as recommended by The Pediatric/Adult Asthma Coalition of New Jersey , The American Lung Association & NJDHSS)**
    Yes ____ No_____

17. **If your child were to suffer a severe attack in school, (not relieved by medication or rest), it is our policy to call 911 & the parents. Is there any additional action you would like taken in the event of such an emergency? If so, please describe:_____**

Parent/Guardian's) Signature:_____ Date:_____