Asthma Questionnaire

South Brunswick Township Public Schools

Student’s Name ___________________________ Date of Birth ___________________________ Grade _____________________

Name of Physician treating child’s asthma _____________________________________________________________________________

Physician’s Address _________________________________________________________________ Phone ____________________

1. How long has your child had asthma or RAD (Reactive Airway Disease)? _________________________________________________

2. Please rate the severity of your child’s asthma or RAD (Circle)
   (Not Severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

3. How many days of school has he/she missed last year due to asthma or RAD related episodes? ________________________________

4. What triggers (“brings on”) your child’s asthma or RAD? (Please check all that apply)
   _____Illness _____Exercise _____Medications _____Foods _____Fatigue
   _____Emotions _____Weather _____Pets _____Cigarette or other smoke
   _____Chemical odors (i.e. perfume) _____Other (Please specify)
   _____Allergies (please list all allergies) __________________________________________________________________

5. What does your child do at home to relieve wheezing or coughing during an asthma or RAD episode? (Please check all that apply)
   _____Breathing exercises _____Rest/Relaxation _____Drinks liquids
   _____Takes medication _____Uses an Inhaler/Nebulizer

6. If your child takes medications, please complete the following chart.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
<th>How is it administered?</th>
<th>When is it needed?</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>(How often is it given)</td>
<td>(Inhaler/Nebulizer/Oral)</td>
<td>(Every day, certain symptoms)</td>
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7. Who is responsible for remembering to take the medication at home?
   _____Parent/Guardian _____Child _____Both, parent and child

8. Does your child experience any side effects from his/her medication? _____Yes _____No
   If yes, please explain ____________________________
9. Has your child been taught to use any of the following devices? (Please check all that apply)

- Extension tube
- Spacer
- Pulmonary Aid
- Inspirease Kit

Other (Please specify) ________________________________________________________________

10. In the past year, how many times has your child been hospitalized for an asthma/RAD episode? _______________________________

11. How often does your child see his/her pediatrician or asthma specialist for routine asthma/RAD check ups?

____________________________________________________________________________________

12. Do you know what your child’s baseline peak flow rate is?

- No
- Yes - Baseline is _________________________________________________________________

13. Have either you or your child attended an asthma education class?

- Child: Yes
- Parent/Guardian: Yes
- Both Parent & Child: Yes
- Child: No
- Parent/Guardian: No
- Both Parent & Child: No

14. Will your child need medication to be kept in school?

- No
- Yes - If yes, please see the school nurse to discuss and obtain proper medication forms.

15. While in school, does your child need any special considerations related to his/her asthma?

Please check all that apply and describe.

* Modified gym class _________________________________________________________________

* Modified recess _________________________________________________________________

No animal pets in classroom _______________________________________________________

Avoiding certain foods _____________________________________________________________

Emotional or behavior concerns _____________________________________________________

Special consideration while on field trips _____________________________________________

Observation for medication’s side effects ____________________________________________

Other ____________________________________________________________

*If your child requires modifications to gym class or recess, please have your physician write a note explaining the necessary modifications and forward to the school nurse. She will review the modifications with the physical education teacher.

(Parent/Guardian Signature) ____________________________________  (Date) ______________