DOES YOUR CHILD HAVE ASTHMA?

- **No** – STOP HERE
- **Yes** – Please complete this form

If you have any questions, please contact your child's school nurse.

Date form completed:_____ Student ID_____

Student Name: _____ Birth date:_____

Parent/Guardian Name & Phone #:_____

Name of person completing form and relationship (i.e. mom, dad, grandma):_____

Health Care Provider for asthma (name & phone #):_____

1. In the past 12 months, how many times has your child visited the ER/urgent care or had an urgent doctor's office visit for asthma?
   0 times 1 times 2 times 3 times 4 times 5 or more times

2. In the past 12 months, how many times has your child been hospitalized overnight for asthma?
   0 times 1 times 2 times 3 times 4 times 5 or more times

3. In the past 12 months, how many times has your child used oral steroids (prednisone, Orapred) to treat an asthma attack?
   0 times 1 times 2 times 3 times 4 times 5 or more times

4. How many days of school did your child miss this past school year because of asthma?
   0 days 1-2 days 3-5 days 6-10 days 11-15 days 15 or more days

5. In the past 4 weeks, how often has your child used a rescue or reliever medicine (a syrup, inhaler, or breathing machine) to relieve coughing, trouble breathing, or wheezing?
   Never 1-2 days/week 3 or more days/week but not every day Every day

6. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day?
   Never 1-2 days/week 3 or more days/week but not every day Every day

7. In the past 4 weeks, how often has your child awakened at night because of coughing, trouble breathing, or wheezing?
   Never 1-2 times/month 3 or more times/month 2 or more times/week Every night

8. In the past 4 weeks, how often has your child's asthma bothered or interrupted him/her during normal activities (playing, running around, and sports)?
   Never Rarely Sometimes Often All of the time

9. What triggers your child's asthma? (Check all that apply)
   Illness (colds) Smoke Allergies: Cat Dog Dust Mold Pollen
   Emotions (crying, laughing, stress) Exercise/physical activity Food: _____
   Weather changes Strong odors/smells Other:_____

10. Please write the names or colors of medicines (inhalers/puffers, pills, liquids, nebulizers) your child takes for asthma and allergies (the ones every day and as needed) and give the nurse a copy of your written asthma treatment plan.

List Names or Colors of Medicines Used for Asthma	

11. How well does your child take asthma medicines? (Only one answer)
    Takes medicine by self Needs help taking medicine Not using medicine now

Parent Signature_____ Date_____ School Nurse Reviewed_____ Date_____