Crossroads Charter Schools

Asthma History - Parent Questionnaire

***To be filled out by a parent or guardian of a new student with asthma, or any student with a new diagnosis of asthma.*

Student Name: _____ Date of Birth: _____ Today's Date:_____

Asthma Health Care Provider: _____ Provider's Phone number _____

1. Have you submitted a copy of your child's most recent asthma action plan or other asthma documentation from your child's health care provider? ▢ Yes ▢ Not yet, but will bring it to the nurse by _____
2. When was your child first diagnosed with asthma? _____
3. ***In the last 3 years***, has your child required the use of asthma medications (includes inhalers)? _____
4. What signs and symptoms signal a flare in your child's asthma? _____

_____

5. Describe any special care your child requires at school. _____

_____

6. Describe needed special considerations for field trips, after-school activities and exercise. _____

_____

7. How many days did your child miss last school year due to asthma concerns?

   ▢ 0 days ▢ 1-2 days ▢ 3-5 days ▢ 6-9 days ▢ 10-14 days ▢ over 15 days

8. During the past year, has your child's asthma ever stopped him/her from taking part in physical activities?

   ▢ none ▢ some of the time ▢ all of the time

9. In the past month, <u>during the day</u>, how often has your child had difficulty with coughing, wheezing or breathing?

   ▢ 2 times a week or less ▢ More than 2 times a week ▢ all the time, throughout the day

10. In the past month, <u>during the night</u>, how often has your child had difficulty with coughing, wheezing or breathing?

    ▢ 2 nights a month or less ▢ 2+ nights a month ▢ 2+ nights a week ▢ 4+ nights a week

11. List any needs you or your child have for additional education about asthma:_____

_____

12. I rate my child's need to improve skills for self-management of asthma (use of inhalers, recognizing symptoms, etc.) as:

    ▢ no need ▢ very low ▢ low ▢ moderate ▢ high ▢ very high

13. I rate my child's health problems related to asthma currently as:

    ▢ no need ▢ very low ▢ low ▢ moderate ▢ high ▢ very high

14. I rate my level of concern about asthma posing a safety risk for my child at school as:

    ▢ no need ▢ very low ▢ low ▢ moderate ▢ high ▢ very high

15. Triggers that may cause an asthma attack or flare up:

- ❑ Exercise
- ❑ Pollens
- ❑ Molds
- ❑ Animal Dander
- ❑ Temperature changes
- ❑ CIgarette smoke, strong odors
- ❑ Respiratory infections
- ❑ Emotions (i.e. when upset)
- ❑ Foods ___________________________
- ❑ Other triggers ___________________________

16. Routine asthma medication schedule

Medication Name	Dose	Frequency	Time administered at home (or as needed)	Needed at school?***

*** *Please note that all medications that are administered at school must be brought in by a parent/guardian and must include the original pharmacy label. A signed copy of the parent medication authorization form is required each school year. Students are not allowed to bring any medications to or from school.*

Please list an emergency contact for your child, in case we can't reach the guardian filling out this form:

Emergency Contact Name: ____

Relation to child: _________________________________ Phone # ____________________________

By signing below, I, the parent or guardian of _____________________________, agree to notify the School Nurse of any changes in my student's health status or changes in orders from the student's healthcare provider, and to provide necessary supplies and medications.

Parent/Guardian Name: ____

Parent/Guardian Signature:____ **Date:** ____________________

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For Health Office Use

▢ Relevant information entered into EHR

▢ Emergency Action Plan Completed

School Nurse Signature: ____ Date: ________________________