Dekalb County Eastern CSD

Questionnaire for Parents of a Child with Asthma

Asthma can be a life threatening condition. The following information is helpful to your child's school nurse and school staff in determining the care for your child. Answer the questions to the best of your ability. If you desire a conference with the school nurse, please call for an appointment.

Student Name ______________________________________ Grade/Teacher ______________________

School _______________________________________ School Nurse _______________________

Parent/Guardian ____

Telephone ____________________ (Home) ____________________ (Work) ________________________ (Cell)

Emergency Contact _____________________________________ Telephone _________________________

Asthma Doctor (print) ___________________________________ Telephone _________________________

Address ____

Hospital Preference ____

Student's History

1. At what age was your child diagnosed with asthma? _______________
2. Number of hospitalizations _______ Emergency Room visits _______ Overnight stays ______
3. Rate the severity of your child's asthma (circle one).
   (not severe) 1 2 3 4 5 6 7 8 9 10 (severe)
4. School days missed last year AS A RESULT OF ASTHMA ________
5. How often does your child see his/her doctor for routine asthma evaluations? _____________
6. Date of last visit to asthma doctor ____________________________

Student's Asthma Triggers

Triggers	Explain
Allergens (dust mites, mold, pollens, cockroaches, animal dander, medications, insect stings, latex, etc.)	
Bacterial and/or viral infections (colds/flu, etc.)	
Environment (weather changes, heat, cold, humidity,etc.)	
Irritants (perfume, paint fumes, smoke, chalk dust, cigarettes, etc.)	
Psychological stresses (anxiety, fatigue, etc.)	
Vigorous exercise (sports, recess, gym, etc.)	

Student's Treatment Plan (check any that apply)
How do you relieve your child's asthma at home?

______ Breathing exercises ______ Rest/relaxation _____ Drink liquids
______ Take medications ______ Other ____
Inhaler Nebulizer

If your child suffers a **severe attack at school**, what plan of action do you prefer school personnel take?
____
____
____

Student's Emergency Allergies

Does your child have any life-threatening allergies (medication, insect bites, foods, etc.)? Yes No

Name allergy/allergies ____

Seen in Emergency Room? Yes No Required hospitalization overnight? Yes No

My child has an ***Epi Pen*** for emergency treatment Yes No

Special considerations related to your child's asthma while at school (circle any that apply).

Restrictions below need to be accompanied with a physician order.

Modified gym class	Modified Recess	Modified field trips
No pets in the classroom	Avoiding certain foods	Observe for medication side effects

I understand and agree that the above information may be shared with school staff. If there are any changes in the above information, I will notify the school nurse as soon as possible. I understand that if my child receives medication at school, the **Authorization for Administration of Medication** *form must be completed and signed. I also understand it is my responsibility to notify the school nurse, in writing, and complete the necessary forms if I feel that my child should self-carry/administer his/her emergency medication while at school or during school activities.* I authorize the school nurse to contact my child's physician about my child's asthma. This authorization shall continue until I notify the school nurse, in writing, that I revoke that authorization.

______________________________________ ____________________
Parent/Guardian Signature Date