Hopewell Valley Regional School District
Division of Pupil Services
425 South Main Street
Pennington, NJ 08534

ASTHMA QUESTIONNAIRE FOR PARENTS

Child's name _____ Birth date _____ Home phone _____

Parent 1 name _____ Cell phone _____ Work phone _____

Parent 2 name _____ Cell phone _____ Work phone _____

Emergency contact _____ Cell phone _____ Home phone _____

Physician's name _____ Telephone _____

1. How long has your child had asthma? _____
2. Please rate the severity of his/her asthma (*please circle using scale below*)
   [Not severe] 0 1 2 3 4 5 6 7 8 9 10 [Severe]
3. Approximately how many days did he/she miss school last year due to asthma? _____
4. Was your child in the emergency room or hospitalized in the past year for asthma? _____
   If yes, please explain. _____
5. How often does your child see his/her doctor for routine asthma evaluations? _____
6. What triggers your child's asthma (*please check all that apply*)
   ☐ Illness ☐ Emotions ☐ Weather ☐ Exercise ☐ Cigarette smoke ☐ Strong odors
   ☐ Dust mites ☐ Mold ☐ Stress ☐ Pets / dander ☐ Plants / grass / flowers / pollen / ragweed
   ☐ Pests – rodents / cockroaches ☐ Foods ☐ Other _____
7. Does your child have any other allergies? ☐ YES ☐ NO
   If yes, explain type and treatment. _____
8. What does your child do to relieve asthma symptoms? (*please check all that apply*)
   ☐ Breathing exercises ☐ Rest / relaxation ☐ Drinks / liquids ☐ Other _____
   ☐ Medication ☐ Inhaler ☐ Spacer ☐ Nebulizer ☐ Oral
9. What medications does your child take and how often?
   Daily: _____
   Just for wheezing / attacks: _____
   Before exercise: _____
   Just certain times of the year (season) or when ill: _____
10. What medication might your child need to take in school? (Please contact the school nurse regarding the district's policy on the administration of medications, including the self-administration of inhalers in school).

    _____

    _____
11. Does your child have any side effects from these medications? (please specify)

    _____
12. Does your child use a peak flow meter? ☐ YES ☐ NO Type: _____
    What are his/her peak flow ranges? Green zone Yellow zone Red zone
13. Are there any special considerations your child needs at school? (*check all that apply and describe*)
    ☐ Gym / recess restrictions or limitations _____
    ☐ Animals / pets in classroom _____
    ☐ Avoiding certain foods _____
    ☐ Other _____

_____ _____
Parent's Signature Date