Romeo Community Schools Asthma Parent Questionnaire

School Year: _____ School:_____

Student: _____ Teacher:_____ Grade: _____

Parent/Guardian: _____ Phone #_____

Transportation: (Circle One) Parent drop-off Bus SACC (AM/PM)

- At what age was your child's asthma diagnosed? _____
- Physician that treats your child's asthma: _____
- When was the last time the doctor was seen for asthma care? _____
- How severe is your child's asthma? □ Mild □ Moderate □ Severe
- What are your child's usual symptoms during an asthma attack?
  - Tightness in chest
  - Shortness of breath
  - Cough
  - Wheezing
  - Other (please describe):

- What triggers your child's asthma?
  - Exercise
  - Allergies (Please List)
    - If Allergies: Does your child need any emergency medication?
  - Illness
  - Stress
  - Cold
  - Smoke (is your child around anyone that smokes? Yes / No)
  - Other

❖ How often does this occur? _____

❖ What medications is your child currently using to control or treat asthma symptoms?

Name of Medicine	What is the dose?	When is it used?

❖ Does your child know when he/she needs medicine? o Yes o No

❖ If your child uses an inhaler, is a spacer used? o Yes o No

Parent Signature: _____

School RN Signature: _____

- **Does your child need medication at school?** o Yes o No

Parent Signature: _____

School RN Signature: _____