

PARENT ASTHMA QUESTIONNAIRE



Student Name: _____ Teacher: _____

Medications that have been prescribed for use at school and at home may be administered by a school nurse or authorized staff member if: 1) the medication has been appropriately labeled by a pharmacist under the direction of a licensed health care provider 2) the parent or legal guardian has granted permission below for the specific medication to be administered at school.

Medication Name _____ Dose _____ Time/Interval _____

Route/inhalation device _____ Instructions _____

Medication Name _____ Dose _____ Time/Interval _____

Route/inhalation device _____ Instructions _____

Allergies: list known allergies to medications, food, or air-borne substances _____

- * How many times in the last 3 years has your child required urgent or emergency care due to asthma? ____ When? _____
* How many times in the last 3 years has your child been hospitalized due to asthma-related problems? ____ When? _____
* Has your child been instructed to take a medication daily to control asthma? _____ If so, when? _____
* Has your child recently been waking up at night coughing? _____ If so, how many nights a month? _____
* Has your child recently been coughing and draining a lot of daytime mucous? _____ If so, how often? _____
* Has your child had asthma symptoms that are worse in certain seasons? _____ If so, what seasons? _____

If the answer to any of these questions is yes, please call _____ to schedule a time to meet with the school nurse. A history and needs assessment form should be completed. An asthma action plan should also be on record with the school.

I, the parent or legal guardian of the student listed above, give permission for administration of the above listed medications. I also grant permission for exchange of information with the health care provider to facilitate my child's asthma and allergy care.

Parent/Guardian:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Emergency Contacts:

Name: _____ Phone: _____

Student's Health Care Provider:

Name: _____ Phone: _____

Address: _____ Fax: _____

Signature of parent/legal guardian _____ Date _____