PITTSFORD CENTRAL SCHOOL DISTRICT
Parent Interview Questionnaire for Individualized Health Plan
ASTHMA

Child’s Name ___________________________ Birthdate __________ Age _____ Grade _____
Teacher ___________________________ Information provided by __________ Date __________

Please answer all questions. Use the back of this form for explanation or any additional information you feel important for us to know.

Who does your child see for regular health visits? ___________________________ Phone __________
Who does your child see for asthma management? ___________________________ Phone __________
When was your child diagnosed with asthma? ___________________________ at age __________

Has your child been diagnosed with any other medical conditions?
☐ No ☐ Yes (explain) ______________________________________________________________________

What symptoms does your child experience during an asthma episode? ______________________________________________________________________

How would your child describe these symptoms? ______________________________________________________________________

How often does your child experience asthma symptoms? ______________________________________________________________________

Does your child use a quick relief inhaler (Albuterol/ Ventolin/ Proventil, etc.) more than 2 times per week? (This does not include using it before physical activity). ☐ No ☐ Yes (explain) ______________________________________________________________________

What triggers (allergens, irritants, exercise, respiratory infections, changes in temperature) cause asthma symptoms for your child? ______________________________________________________________________

Has your child gone to the emergency room or been hospitalized for treatment of asthma?
☐ No ☐ Yes (explain) ______________________________________________________________________

What medications does your child take to manage his/her asthma?

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<tr>
<th>Name of Medication</th>
<th>Amount</th>
<th>When taken</th>
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Has your child been instructed on when and how to take these medications independently? ☐ No ☐ Yes

Is your child participating in sports or school sponsored extracurricular activities? ☐ No ☐ Yes

Does your child carry his/her inhaler in school and at these activities? ☐ No ☐ Yes

Has asthma caused your child to be restricted from physical education/recess activities?
☐ No ☐ Sometimes ☐ Often (explain)

Has asthma caused your child to miss school? ☐ No ☐ Yes Number of days missed last year __________

Has your physician completed an Asthma Action Plan for your child? ☐ No ☐ Yes

Have you and/or the physician reviewed the Asthma Action Plan with your child? ☐ No ☐ Yes

Does your child use a peak flow meter? ☐ No ☐ Yes

Is your child comfortable alerting others when experiencing asthma symptoms? ☐ No ☐ Yes

Does your child wear a “medic alert” necklace/bracelet? ☐ No ☐ Yes

Do you feel your child’s understanding of his/her asthma is:
☐ very good ☐ good ☐ fair ☐ limited

Has your physician indicated in writing that your child needs any special accommodations to participate in school activities? ☐ No ☐ Yes (explain) ______________________________________________________________________

Comments: ______________________________________________________________________
______________________________________________________________________________
TO BE COMPLETED BY THE STUDENT’S PHYSICIAN

Student’s Name ___________________________ Date of Birth __________________

Medication _______________________________ Dose ______ Route ______ Time(s) ______

Purpose __________________________________________________________________________________________

Side Effects _______________________________________________________________________________________

All medications should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Physician please check if applicable:

☐ If morning dose is not given at home, nurse may administer morning dose of ____________________ after verbal or written notification from parent.

☐ Medication should be taken on field trips.

☐ Medication should be given during school sponsored after school and/or weekend activities/sports

Physician’s Signature ___________________________ Date __________________

Physician’s Name (Please Print) ___________________________ Phone __________________

I give permission for the above medication to be administered to my child as ordered by my health care provider and for the school nurse to share information with physician regarding this medication.

Parent’s Signature ___________________________ Date __________________

Permission for Students to Carry Medication

A student may self-carry if:

- The student is in grades 6-12. An exception to this rule is when the medication is a metered dose inhaler for asthma, an Epi-Pen, diabetic medication or Lactaid in which case younger students may be permitted to carry and self-administer.

- The medication is not: a controlled substance, psychotropic, for ADHD, or contains dextromethorphan (DMX) or stimulant decongestants.

- An assessment by the school nurse confirms that the student is self-directed to carry and self-administer her/his medication properly.

- Parent assumes responsibility for insuring that his/ her child is carrying and taking the medication as ordered.

I give permission for this student to self-carry and self-administer the above medication as I consider her/him responsible. He/She has been instructed in and understands the purpose and appropriate method and frequency of administration of this medication.

Physician’s Signature* ___________________________ Date __________________

I assume responsibility for ensuring that my child is carrying and taking his/her medication as ordered.

Parent’s Signature ___________________________ Date __________________

* A licensed prescriber is required for all medications including all over the counter (OTC) and prescription medications.

* A non-parent licensed prescriber is required for all controlled medication.

Nurse/ Health ManualV/Roselli
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