

For Parent/Guardian to complete

* Please provide the completed questionnaire (questions 1-13) to the child's Primary Medical Provider; Medical Provider to complete the **Asthma Action Plan**

- Return the entire packet to Child and Youth Services Central Registration after it is completed-

Asthma Action Plan Questionnaire

Child/Youth Name: _____

DOB: _____

1.) Has (s)he ever been taken to the clinic or E.R. for an acute asthma attack? Yes No
When was the last time?

2.) Has (s)he ever been admitted to the hospital for asthma? Yes No
When was the last time?

3.) Has (s)he ever been admitted to an Intensive Care Unit (I.C.U) for asthma? Yes No
Was (s)he on a ventilator? Yes No

4.) Has (s)he taken steroids orally for asthma? No
 Yes, for a few days during a flare-up
-OR-

Yes, for an extended period (over one month continuously)
When was the last time (s)he used oral steroids? _____

5.) What medications does (s)he currently use for asthma? (must include all strengths and doses as they apply)

a.) "Rescue": Albuterol MDI (inhaler) Albuterol nebulizer
 Xopenex Other: _____

b.) "Controller": Flovent MDI (inhaler) 44 110 220
 Pulmicort nbulizer 0.25 0.50
 Advair 100/50 250/50 500/50

c.) "Other": Servent Intal (cromolyn)
 Singulair 4mg 5mg 10mg
 Prednisone
 Other: _____

d.) Does s(he) use a spacer? Yes No

6.) How often does s(he) require "rescue" medication?

Less than once a week

Once a week or more

Daily

7.) How often does s(he) have daytime wheezing, cough, or shortness-of-breath?

Twice a week or less

More than twice a week

Daily

Continually

8.) How often does s(he) have nighttime wheezing, cough or shortness-of-breath?

Twice a month or less

More than twice a month

Weekly

Daily

9.) Does your child use a Peak Flow Meter (generally, 8 years and older)? Yes No

What is his or her best predicted Peak Flow? _____

10.) Please check any known "triggers" for asthma symptoms:

Exercise

Weather changes

Illness (colds)

Cold Air

Animal Fur

Anxiety or emotional issues

Allergens (mold, pollen, dust, etc.)

Irritants (tobacco smoke, chalk dust, etc.)

Other: _____

Other: _____

11.) How well do you feel your child's asthma is controlled?

Very well

Well

Somewhat

Not at all

12.) Has your child ever been referred to a specialist for asthma? Yes No

13.) Have you and your child been to the Disease Management Clinic for asthma? Yes No

Parent's/Guardian's Signature and Date