

6. How well does your child take his/her asthma medication(s)?

self-administers needs help/supervision

7. In the past 4 weeks, how often has your child used a rescue medication (oral syrup, inhaler or nebulizer) to relieve coughing, trouble breathing, or wheezing?

never 1-2 days/week 3 or more days/week but not everyday everyday

8. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day?

never 1-2 days/week 3 or more days/week but not everyday everyday

9. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing at night while sleeping?

never 1-2 nights/week 3 or more nights/week but not every night every night

Parent Signature: _____ **Date:** _____

School Nurse notes: _____

Nurse Signature: _____ Date: _____