



# Parent Truancy Officer Asthma Screening Questionnaire

**For all students absent due to asthma ask the following questions and circle yes or no for each.**

**1. Do you/your child live in one of the following zip codes?**

(circle zip)

**Yes      No**

19104, 19121, 19122, 19123, 19130, 19131, 19132, 19133,  
19134, 19139, 19140, 19141, 19142, 19143, 19144, 19145,  
19146, 19147, 19148, 19151, 19153

**2. Does your child take any of the following medications?**

(circle which ones)

**Yes      No**

Accolate    AeroBid    Advair    Azmacort    Flovent  
Pulmicort    Serevent    Singulair    Vanceril

**3. Has your child been to the emergency department with a severe asthma attack two or more times in the past year?**

**Yes      No**

**4. Has your child stayed in the hospital overnight for asthma in the past year?**

**Yes      No**



**Box 1**

If answered **YES** to questions 1, 2 and 3

**OR**

If answered **YES** to questions 1, 2, and 4

➤ **Inform parent of CAPP home visit program (see sample script)**

**Box 2**

If answered **NO** to questions 1 **or** 2

**OR**

If answered **NO** to questions 3 **and** 4

➤ **Inform parent of CAPP's FREE asthma classes (see sample script)**

Referral form completed (return to coordinator)

Given class flyer

Date \_\_\_\_\_ PTO signature \_\_\_\_\_

**COORDINATORS: Please fax (both sides) to Confidential CAPP Fax #: 267-426-5774**