DOH ID: **HD002328**

Student Name _____

Kickin' Asthma Facilitators may fold or tear along this line to submit de-identified data after completing the Unique ID field

Facilitator Section **POST**

Student Unique ID_____ Date _____
School/Location Name

_____

Did the student complete Q1-Q14 (below) independently?

☐ No – I provided assistance (e.g., by reading the questions aloud)

☐ Yes – the student completed this independently, without any assistance

Facilitators should complete the fields above. Write out the full school name, do not use abbreviations.

Hello! We would like to ask you some questions about the program and about your asthma. This is **not** a test. We would like you to answer the questions honestly. We respect your privacy. When you submit your answers, they will not be saved with your name. No one will be able to know which answers you gave. This survey is controlled by the Research & Evaluation Group at Public Health Management Corporation, who will share all de-identified survey responses with the American Lung Association.

Please answer the following questions about yourself:

What **grade** are you in? _____

What is your age? _____

Have you ever **participated in Kickin' Asthma before**?

☐ No, this is my first time
☐ Yes, I've done this before
☐ I'm not sure

Please answer the following questions about your asthma:

1) How often do you **tell an adult** when you have trouble breathing?

☐ None of the time
☐ Some of the time
☐ Most of the time
☐ All of the time

2) How often do you **use a spacer** when you use your asthma inhaler?

☐ None of the time
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ I don't have a spacer

Remember to **turn the page!**

3) How often do you **use a peak flow meter** when you feel your breathing getting worse?

- ☐ None of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ I can't tell when my breathing is getting worse

4) Which of the following are asthma triggers? (Check all that apply.)

- ☐ Mold
- ☐ Exercise
- ☐ Smoke
- ☐ Pollen
- ☐ Cold Weather

5) What asthma medication should you take right away if you have trouble breathing?

- ☐ Quick Relief Inhaler
- ☐ Controller Inhaler
- ☐ All of the above
- ☐ None of the above

6) What happens during an **asthma episode**? (Check all that apply.)

- ☐ Muscles around the airways get tight
- ☐ Swelling in the airways
- ☐ Extra mucus in the airways
- ☐ None of the above

7) In the **past 3 months**, how many times did you go to the emergency room because of breathing problems or asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5-10
- ☐ More than 10 times

8) In the **past 3 months**, how many times have you stayed in the hospital because of breathing problems or asthma?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5-10
- ☐ More than 10 times

9) In the **past 4 weeks**, how many days per week (7 days) did you take your control medicine as prescribed (by your doctor)?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ I don't have a control medication

Remember to **turn the page!**

Part 2: Asthma Control Test adapted from GlaxoSmithKline

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?

All of the time (1)	Most of the time (2)	Some of the time (3)	A little of the time (4)	None of the time (5)

2. During the past **4 weeks**, how often have you had shortness of breath?

More than once a day (1)	Once a day (2)	3 to 6 times a week (3)	Once or twice a week (4)	Not at all (5)

3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

4 or more nights a week (1)	2 or 3 nights a week (2)	Once a week (3)	Once or twice (4)	Not at all (5)

4. During the past **4 weeks**, how often have you used your quick relief inhaler or nebulizer medication (such as albuterol)? Do not count the times you used it to exercise if your doctor says to take medicine when you exercise.

3 or more times per day (1)	1 or 2 times per day (2)	2 or 3 times per week (3)	Once a week or less (4)	Not at all (5)

5. How would you rate your **asthma** control during the past **4 weeks**?

Not controlled at all (1)	Poorly controlled (2)	Somewhat controlled (3)	Well controlled (4)	Completely controlled (5)