

DOH ID: HD002332

Student Name _____

Open Airways Facilitators may fold or tear along this line to submit de-identified data *after* completing the Unique ID field

Facilitator Section

1 month Follow Up

Student Unique ID _____ Date _____

School/Location Name _____

















Did the student complete Q1-Q4 (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.

Asthma Control Test from  GlaxoSmithKline

Have the child complete these questions.

1. How is your asthma today?				SCORE
 0 Very bad	 1 Bad	 2 Good	 3 Very good	<input type="checkbox"/>
2. How much of a problem is your asthma when you run, exercise or play sports?				
 0 A big problem - I can't do what I want to do.	 1 A problem - I don't like it.	 2 A little problem, but it's okay.	 3 It's not a problem.	<input type="checkbox"/>
3. Do you cough because of your asthma?				
 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.	<input type="checkbox"/>
4. Do you wake up during the night because of your asthma?				
 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.	<input type="checkbox"/>