OSSEO AREA SCHOOLS
ISD 279

Return to your child's school health office

REACTIVE AIRWAY DISEASE (RAD) or ASTHMA QUESTIONNAIRE

An Update for the Health Record

Student_____ Birth Date_____

School Name_____ School Year_____ Grade_____

Physician_____ Clinic_____ Phone_____

Parent_____ Phone: Cell_____ Work_____

Parent_____ Phone: Cell_____ Work_____

History

- Your child's age when RAD or asthma was first diagnosed. _____
- When was your child last seen by his/her physician for RAD or asthma? _____
- How severe is your child's RAD or asthma?
  □ Mild □ Moderate □ Severe □ No longer a problem
- When does your child have symptoms? □ throughout the year □ when exposed to triggers
  □ other _____
- How many days would you estimate he/she missed school last year due to RAD or asthma? _____
- In the past year, how many times has your child been treated for RAD or asthma..
  In the emergency room? _____ Hospitalized? _____How many days?_____
- Does your child take any medications at this time for his/her RAD or asthma condition? □ Yes □ No
- Does his/her RAD or asthma medication keep symptoms under control, or are there times when your child has symptoms even when on medication? □ Yes □ No

Identified Triggers

- What triggers your child's RAD or asthma attacks? (Check any that apply)
  □ exercise □ cold air □ illness
  □ smoke □ dust □ allergies to _____
  □ stress □ animal □ other_____

Symptoms

- Check your child's usual signs/symptoms of a RAD or asthma attack/episode.
  □ wheezing □ chest tightness □ cough
  □ difficulty breathing □ other _____
- What does your child do at home to relieve symptoms during a RAD or asthma attach/episode?
  □ breathing exercises (belly breathing) □ drinks warm fluids
  □ rest/relaxation □ uses peak flow meter
  □ takes medication: □ oral □ inhaler □ nebulizer
  □ other _____
- Does your child know how to use a peak flow meter? □ Yes □ No
- What are your child's peak flow meter zones? Green:_____Yellow:_____Red:_____
- Has your child had asthma education? □ Yes □ No

Return to your child's school health office

Medications

Medication note: *If medications are to be given during the school day, a medication administration consent form needs to be filled our yearly. Medications must be in a pharmacy labeled container and kept in the health office. A parent/guardian, however, may authorize self-administration on inhalers if the student is deemed capable.*

Please list the medications your child takes for RAD or asthma.

Name	***By (mouth, inhaler, neb)***	***Dose***	***How often***

On a regular basis:

_____

_____

As needed basis:

_____

_____

- Does your child use a spacer device? □ Yes □ No
- Medication kept in the health office? □ Yes □ No Please list: _____

_____

- What if any, side effects does your child have from his/her medication? _____

_____

RAD or Asthma Management at School

- Does your child know when he/she needs medication? □ Yes □ No
- What action do you want school personnel to take, if your child does not respond to treatment/medication? *(Note: In an acute emergency, the student will be transported by paramedics to the hospital. Parent/guardian will be notified as soon as possible. Any charges incurred are the responsibility of the parent/guardian.)*

_____

_____

_____

- Please add anything else that you would like school personnel to know about your child's RAD or asthma or special considerations needed by your student for his/her condition. *(Note: gym/recess medication needs must be documented by a physician note on a yearly basis).*

_____

_____

_____

This information is being requested to assist your child in the prevention and treatment of his/her RAD or asthma condition. This information is available to school staff when necessary in working with your son/daughter. Its use is subject to School District 279 Policy 5710 and the Minnesota Data Privacy Act Statutes.

Parent Signature _____ Date _____