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 attack/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
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.

<table>
<thead>
<tr>
<th>Name</th>
<th>By (mouth, inhaler, neb)</th>
<th>Dose</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ____________________________

HS 20 OVER 03/2016