



Greeley-Evans Weld County School District 6

1025 NINTH AVENUE | GREELEY, COLORADO 80631
970-348-6000 | WWW.GREELEYSCHOOLS.ORG

STUDENT SUPPORT SERVICES

Health Services

If you have any questions, please contact your child's school nurse.

Date form completed: _____ Student ID _____

Student Name: _____ Birth date: _____

Parent/Guardian Name & Phone #: _____

Name of person completing form and relationship (i.e. mom, dad, grandma): _____

Health Care Provider for asthma (name & phone #): _____

- In the past 12 months, how many times has your child visited the ER/urgent care or had an urgent doctor's office visit for asthma?
 0 times 1 times 2 times 3 times 4 times 5 or more times
- In the past 12 months, how many times has your child been hospitalized overnight for asthma?
 0 times 1 times 2 times 3 times 4 times 5 or more times
- In the past 12 months, how many times has your child used oral steroids (prednisone, Orapred) to treat an asthma attack?
 0 times 1 times 2 times 3 times 4 times 5 or more times
- How many days of school did your child miss this past school year because of asthma?
 0 days 1-2 days 3-5 days 6-10 days 11-15 days 15 or more days
- In the past 4 weeks, how often has your child used a rescue or reliever medicine (a syrup, inhaler, or breathing machine) to relieve coughing, trouble breathing, or wheezing?
 Never 1-2 days/week 3 or more days/week but not every day Every day
- In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day?
 Never 1-2 days/week 3 or more days/week but not every day Every day
- In the past 4 weeks, how often has your child awakened at night because of coughing, trouble breathing, or wheezing?
 Never 1-2 times/month 3 or more times/month 2 or more times/week Every night
- In the past 4 weeks, how often has your child's asthma bothered or interrupted him/her during normal activities (playing, running around, and sports)?
 Never Rarely Sometimes Often All of the time
- What triggers your child's asthma? (Check all that apply)
 Illness (colds) Smoke Allergies: Cat Dog Dust Mold Pollen
 Emotions (crying, laughing, stress) Exercise/physical activity Food: _____
 Weather changes Strong odors/smells Other: _____

10. Please write the names or colors of medicines (inhalers/puffers, pills, liquids, nebulizers) your child takes for asthma and allergies (the ones every day and as needed) and give the nurse a copy of your written asthma treatment plan.

List Names or Colors of Medicines Used for Asthma	

- How well does your child take asthma medicines? (Only one answer)
 Takes medicine by self Needs help taking medicine Not using medicine now

Parent Signature _____ Date _____ School Nurse Reviewed _____ Date _____