Carroll County Public Schools
Parent Health Questionnaire – Respiratory

Student Name: _____ Date: _____
Date of Birth: _____ Grade: _____

You have indicated on the Emergency Procedure Card and/or health forms that your child has or has a history of asthma, reactive airway disease (RAD), or other respiratory concern. Please complete the following questionnaire and return to your school nurse as soon as possible.

1. Please indicate which diagnosis applies to your child:
   __Asthma __ Reactive Airway Disease (RAD) __ Other:_____

2. At what age did the child's symptoms start? _____

3. Describe symptoms experienced by child during an exacerbation (circle all that apply):

Wheezing	Dizziness	Anxiety/Panic	Tight chest
Coughing	Shortness of Breath	Hoarse Voice	Difficulty Speaking
Nasal Flaring	Blue Lips	Hoarse Voice	Difficulty Speaking
Other:_____			

4. Common triggers (circle all that apply):
   Seasonal Allergies Weather/Temperature Changes Emotions
   Activity Illness Other:_____

5. In the past 12 months, how often has your child had an episode?
   □ Daily □ Weekly □ Monthly Other:_____

6. Within the past 12 months, how often has your child had episodes that resulted in:
   Hospitalizations: ____ time(s) Date of last hospitalization: _____
   Visit to the ER: ____ time(s) Date of last ER visit: _____

7. Does your child understand their condition and what he/she should do to manage it? Please describe:

   _____

   _____

8. List current medications:

Medication	Dose	How often used:	Side Effects

Carroll County Public Schools
Parent Health Questionnaire – Respiratory

Student Name: _____ Date: _____
Date of Birth: _____ Grade: _____

9. Will any medications be needed at school? If so, which medications?
   _____

10. If a student is unable to participate in the physical education program for a period in excess of three consecutive days, a physician's statement is required. The physician should state the nature of the disability/illness and the length of time the student's activity is restricted (please request PE modification form as needed).

11. Name and phone number of Health Care Provider managing treatment:
    Health Care Provider name: _____
    Phone Number: _____

Please note: Medication will only be given following CCPS Medication Procedures. The information you supply will be handled in a confidential manner to be used by the school nurse to guide care if an emergency arises. If clarification is required beyond this form, the nurse will contact the parent/guardian and/or the child's health care provider. If you have questions, please call the school nurse.

_____ _____
Parent/Guardian Signature Date

Received by School Nurse:

_____ _____
Nurse Signature Review Date

7/2018
Rev. 7/2024