**ST. VRAIN VALLEY SCHOOL DISTRICT**
**STUDENT SERVICES**

# REACTIVE AIRWAY DISEASE OR ASTHMA QUESTIONNAIRE

Student Name: ________________________________________ Birthdate: _____________________
School Name: ________________________________________ Grade: ______________________
Dear Parent/Guardian:
Please provide the following information on your child's asthma or reactive airway disease to help us understand your child's health needs.

## 1. HISTORY AND CHARACTERISTICS OF SYMPTOMS:

At what age did your child's asthma start? __________________________________________
When was your child last seen by the doctor for asthma? ______________________________
Physician Name: ________________________________Phone Number: _______________
How many times has your child been hospitalized for asthma? _________________________
How many emergency room visits have been needed for treatment of asthma? ___________
When does your child have symptoms: throughout the year/or only when in contact with triggers and/or certain months? (If monthly, which ones?) ______________________________

Does medication keep symptoms under control, or are there times when your child has Symptoms even when on medication? _____________________________________________

## 2. IDENTIFIED TRIGGERS:

Exercise _________________________ Cold, windy weather _________________________
Illness ___________________________ Chemicals __________________________________
Medications _______________________ Allergies __________________________________
Animals __________________________ Foods ____________________________________
Other: _____________________________________________________________________

## 3. SYMPTOMS:

Please list symptoms in usual order of occurrence when asthma occurs: _________________
_____________________________________________________________________________

## 4. MEDICATIONS:

Please list name, dosage, times and whether taken routinely, or as needed:
Oral medication ______________________________________________________________
Inhalers ____________________________________________________________________
Nebulizer ___________________________________________________________________
Does your child use a spacer device? ____________________________________________
What medications are at school? ________________________________________________
Are they kept in the health office? ______________________________________________

## 5. PEAK FLOW METER:

Does your child use a peak flow meter? __________________________________________
Should one be kept in the health office at school? __________________________________
If yes, what are the readings obtained for the: **Green Zone**? ___________________________
**Yellow Zone**? _________________________**Red Zone**? ____________________________

## 6. COMMENTS? ______________________________________________________________

_____________________________________________________________________________

PLEASE **RETURN** THIS COMPLETED FORM TO THE **HEALTH CLERK** AT YOUR CHILD'S SCHOOL; IT WILL BE SHARED WITH THE SCHOOL NURSE.

Parent Signature: ______________________________ Date: _________________________
Home Phone: __________________________________ Work Phone: ____________________