Comprehensive Care for Chicagoland's
Children with Asthma

RESPIRATORY HEALTH & ALLERGY SURVEY

Please print

Child's name_____
Last First

School _____ Date of Birth _____ Today's Date_____

1. Has your child EVER been diagnosed by a doctor or other health care provider as having asthma?	No	Yes
2. Has your child had episodes of wheezing (whistling in the chest) in the last 12 months?	No	Yes
3. In the last 12 months, have you heard your child wheeze or cough during or after active play?	No	Yes
4. Other than a cold, in the last 12 months, has your child had a dry cough at night?	No	Yes
5. In the last 12 months, has your child been to a doctor, an emergency room or a hospital for wheezing?	No	Yes
6. Does your child have any symptoms of itchy, runny nose, itchy eyes, sneezing, or dry cough when the weather changes, or when they are around certain pets or places?	No	Yes
7. Does your child have a history of any food reaction?	No	Yes

If you answered "yes" to any of the above questions, your child may have asthma or allergy symptoms.

☐ **YES, I would like a call with more information about how to receive a medical evaluation and ongoing treatment for asthma at NO COST for my child.**

Parent name _____
Last First

Home address _____
Street

_____
City/State/Zip Email Address

Please write at least two telephone numbers where you can be reached.

Home ( ) _____-_____

Cell ( ) _____-_____

Work ( ) _____-_____

☐ **No, I am not interested in this free mobile asthma service.**

Please return completed Surveys to:
Orland Township
14807 S. Ravinia Ave. Orland Park, IL 60462
Surveys should be returned no later than Wednesday, September 30, 2020.