South Brunswick School District

ASTHMA QUESTIONNAIRE

Student's Name _____ Date of Birth _____ Grade_____

Parent/Guardian's Name(s) _____Telephone Number _____

Does your child have asthma or RAD (Reactive Airway Disease)? NO - Please DO NOT CONTINUE and sign below

Parent/Guardian Signature _____

YES, please answer the following questions:

Name of Physician treating your child's asthma or RAD_____

Physician's Address _____ Phone _____

1. How long has your child had asthma or RAD ? _____
2. Please rate the severity of your child's asthma or RAD (circle)

   (Not Severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

3. How many days of school did your child miss last year due to asthma or RAD related episodes? _____
4. What triggers (brings on) your child's asthma or RAD ? Please check all that apply.

   _____ Illness _____ Exercise _____ Medications _____ Foods _____ Fatigue

   _____ Emotions _____Weather _____ Pets _____Cigarette or other smoke

   _____ Chemical odors (i.e. perfume) _____ Other (Please specify) _____

   _____ Allergies (Please list all allergies) _____
5. What does your child do at home to relieve wheezing or coughing during as asthma or RAD episode: (Please check all that apply)

   _____ Breathing Exercises _____ Rest/Relaxation _____ Drinks liquids

   _____ Takes medication _____ Uses an Inhaler/Nebulizer
6. If you child takes medications, please complete the following chart.

Name of Medication	Dosage	Frequency	How is it administered ?	When is it needed ?

7. Who is responsible for remembering to take the medication at home ?

   _____ Parent/Guardian _____ Child _____ Both
8. Does your child experience any side effects from the medication ? _____ No

   _____ Yes - Please explain_____

_____ _____ _____

Print Parent/Guardian Name Parent/Guardian Signature Date