South Brunswick Township Public Schools

Asthma Questionnaire

School ______________________ School Year ______________

Student's Name __________________ Date of Birth ______________ Grade ________

Name of Physician treating child's asthma ______________________________

Physician's Address ______________________________ Phone ______________

1. How long has your child had asthma or RAD (Reactive Airway Disease)? ______________

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 has he/she missed 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 an asthma or RAD episode? (Please check all that apply)

   _______Breathing exercises _______Rest/Relaxation _______Drinks liquids
   _______Takes medication _______Uses an Inhaler/Nebulizer

6. If your child takes medications, please complete the following chart.

Medication Name	Dosage	Frequency (How often is it given)	How is it administered? (Inhaler/Nebulizer/Oral)	When is it needed? (Every day, certain symptoms)

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

   _______Parent/Guardian _______Child _______Both, parent and child

8. Does your child experience any side effects from his/her medication? _______Yes _______No

   If yes, please explain ______________________________