



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.

Table with 5 columns: 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 _____

