

South Brunswick Township Public Schools

Asthma Questionnaire

School	School Year					
				Grade		
Name of Physician treating	child's asthma					
Physician's Address			Pho	ne		
1. How long has your child	had asthma or RAD ((Reactive Airway Disease)?			
2. Please rate the severity o	f 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	ol has he/she missed la	ast year due to asthma or	RAD related episodes?			
4. What triggers ("brings or	n") your child's asthm	a or RAD? (Please check all	that apply)			
	ionsWeat ical odors (i.e. perfun	herPets ne)Other (l	Cigarette of Cigar			
Allerg	gies (please list all alle	ergies)				
5. What does your child do	at home to relieve wh	neezing or coughing durin	g an asthma or RAD episode?	(Please check all that apply)		
Breathing exercisesRest/RelaxationDrinks liquids Takes medication Uses an Inhaler/Nebulizer						
6. If your child takes medic	-		Counzer			
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 re	emembering to take th	e medication at home?				
Parent/Guardian		Child	Both, parent and child			
8. Does your child experien	nce any side effects from	om his/her medication?	Yes	No		
If yes, please e	explain					

Extension tube	Spacer	Pulmonary Aid	Inspirease Kit
Other (Please specify)			
10. In the past year, how many times has you	ur child been hospitalize	ed for an asthma/RAD episode?	
11. How often does your child see his/her pe	•	-	
12. Do you know what your child's baseline			
NoYes -Ba	aseline is		
13. Have either you or your child attended at	n asthma education class	s?	
Child:Yes PareNo	ent/Guardian:Yes No	Both Parent & Child:YesNo	
14. Will your child need medication to be ke	ept in school?		
No Yes - If yes, please see t	the school nurse to discu	uss and obtain proper medication forms.	
15. While in school, does your child need an Please check all that apply and describe.	y special considerations	s related to his/her asthma?	
*Modified gym class			
*Modified recess			
No animal pets in classroom _			
Avoiding certain foods			
Emotional or behavior concerns	S		
Special consideration while on	field trips		
Observation for medication's si	ide effects		
Other			
*If your child requires modifications to gym class or red will review the modifications with the physical education		ian write a note explaining the necessary modificat	tions and forward to the school nurse. Sh
(Parent/Guardian Signature)	(Date))	