

Relationship to Student: _____

ABOUT YOUR CHILD

A. General Health

1. *Does your child have the following conditions more than twice a year?*

Colds	Yes	No
Flu	Yes	No
Bronchitis	Yes	No
Skin rash	Yes	No
Ear infection	Yes	No
Sore throat	Yes	No
Sinus infection	Yes	No

2. *Does your child frequently show the following symptoms when he or she is not ill?*

Runny nose	Yes	No
Stuffy nose	Yes	No
Watery eyes	Yes	No
Itchiness	Yes	No
Coughing	Yes	No
Wheezing	Yes	No
Earache	Yes	No
Difficulty sleeping	Yes	No

3. *Does your child have any known allergies?*

Yes **No**

4. *If yes, is he or she allergic to:*

Pets **Yes** **No**

Weed pollen **Yes** **No**

Tree pollen **Yes** **No**

Dust **Yes** **No**

Mold **Yes** **No**

Home chemicals **Yes** **No**

Smoke **Yes** **No**

Foods **Yes** **No**

Other _____

5. *Has your child been diagnosed with any of the following?*

Asthma **Yes** **No**

Allergic rhinitis **Yes** **No**

**Otitis media with
effusion** **Yes** **No**

Sleep apnea **Yes** **No**

Sinusitis **Yes** **No**

Nasal polyps **Yes** **No**

B. Extracurricular Activities

1. *Does your child frequently take part in:*

Football **Yes** **No**

Baseball **Yes** **No**

Soccer **Yes** **No**

Snow sports **Yes** **No**

Other sports _____

2. *Hobbies or modeling in which glue would be used?*

Yes **No**

3. *Activities that might involve exposure to chemicals?*

Yes **No**

ABOUT YOUR CHILD'S FAMILY

Please make a check mark next to the following allergies from which other family members suffer, if applicable:

A. Mother

Pets _____

Weed pollen _____

Tree pollen _____

Dust _____

Mold _____

Home chemicals _____

Smoke _____

Foods _____

Other _____

B. Father

Pets _____

Weed pollen _____

Tree pollen _____
Dust _____
Mold _____
Home chemicals _____
Smoke _____
Foods _____
Other _____

C. Sister(s)

Pets _____
Weed pollen _____
Tree pollen _____
Dust _____
Mold _____
Home chemicals _____
Smoke _____
Foods _____
Other _____

D. Brother(s)

Pets _____
Weed pollen _____
Tree pollen _____
Dust _____
Mold _____

Home chemicals _____

Smoke _____

Foods _____

Other _____

E. Other _____

Pets _____

Weed pollen _____

Tree pollen _____

Dust _____

Mold _____

Home chemicals _____

Smoke _____

Foods _____

Other _____

F. Other _____

Pets _____

Weed pollen _____

Tree pollen _____

Dust _____

Mold _____

Home chemicals _____

Smoke _____

Foods _____

Other _____

ABOUT YOUR CHILD'S HOME

A. General

1. *In what sort of dwelling do you live?*

Single-family house _____

Apartment or condominium _____

Other _____

2. *When, approximately, was the dwelling built?*

In the last 5 years _____

Between 5 and 10 years ago _____

Between 10 and 25 years ago _____

Between 25 and 50 years ago _____

Over 50 years ago _____

3. *Do you have any of these pets?*

Dog _____

Cat _____

Bird _____

Other mammal
(such as hamster) _____

4. *Is the pet often allowed inside the home?*

Yes No

5. *Is the pet allowed to sleep in the child's room?*

Yes No

6. *Does anyone smoke inside the home?*
Yes No

7. *Is the home located near any industrial plants that have regularly functioning smokestacks?*
Yes No

8. *Has the home ever had water damage?*
Yes No

9. *Does the home have air conditioning?*
Yes No

10. *What sort of heating system does the home have?*

Oil _____

Gas _____

Electric _____

Forced air _____

Wood _____

Hot water _____

Other _____

11. *What sort of floors are in the home?*

Bare-wood floors or linoleum _____

Wood floors with throw rugs _____

Wall-to-wall carpets _____

B. Child's Bedroom

1. *What sort of floor covering is in the bedroom?*

Bare-wood floors or linoleum

Wood floors with throw rugs

Wall-to-wall carpets

2. *Is the bed at least 2 feet off the floor?*

Yes

No

3. *What kind of pillows are on the bed?*

Foam _____

Feathers _____

Polyester or synthetic _____

4. *If the bed has a comforter, what is its filling?*

Feathers _____

Cotton _____

Synthetics _____

5. *Does the bedroom contain any of these items?*

Upholstered furniture Yes No

Stuffed animals Yes No

Plants in
wicker baskets Yes No

Books Yes No

Trophies Yes No

6. *What kind of window treatments are in the bedroom?*

Cotton curtains _____

Synthetic curtains _____
Venetian blinds _____
Roller blinds _____
Other _____

C. Bathrooms/kitchens

1. *Is there a problem with mold or mildew?*

Yes No

2. *Are there any signs of water damage?*

Yes No

D. Yard

1. *Are there trees or flowers near your child's bedroom window?*

Yes No

2. *Are there any piles of decaying plant matter near the home?*

Yes No

3. *Are there any strong smells of mold near the home?*

Yes No

Thank you for completing the survey. If you have any questions, please contact _____ at _____.

Student Survey

(School) _____
Self-Assessment Survey

Please answer the questions as accurately and completely as possible by placing a check mark next to the appropriate response or filling in the blank.

Name _____

Homeroom Teacher _____

1. How often are you absent from school?

Very often Occasionally Rarely Almost never

2. How often do you feel sick at school?

Very often Occasionally Rarely Almost never

3. How often do you have any of the following?

	Always	Sometimes	Rarely	Never
<i>Runny nose</i>	_____	_____	_____	_____
<i>Stuffy nose</i>	_____	_____	_____	_____
<i>Watery eyes</i>	_____	_____	_____	_____
<i>Itchiness</i>	_____	_____	_____	_____
<i>Coughing</i>	_____	_____	_____	_____
<i>Wheezing</i>	_____	_____	_____	_____
<i>Earache</i>	_____	_____	_____	_____

Tiredness _____

4. **Do you notice these symptoms more often at a certain time of the year?**

Yes *No*

If yes, when?

Winter _____ *Summer* _____

Fall _____ *Spring* _____

5. **How many times a year would you estimate you suffer with the following:**

Colds _____ *Flu* _____ *Bronchitis* _____

Skin rash _____ *Ear infection* _____ *Sore throat* _____

Sinus infection _____

6. **Do you have any known allergies?**

Yes *No*

7. **Do you often seem to have any of the following symptoms when you are NOT sick?**

Yes **No**

Runny nose _____ _____

Stuffy nose _____ _____

Watery eyes _____ _____

Itchiness _____ _____

Coughing _____ _____

Wheezing _____ _____

Earache _____ _____

Difficulty sleeping _____ _____

8. Are you allergic to any of the following?

	Yes	No
<i>Pets</i>	_____	_____
<i>Weed pollen</i>	_____	_____
<i>Tree pollen</i>	_____	_____
<i>Dust</i>	_____	_____
<i>Mold</i>	_____	_____
<i>Home chemicals</i>	_____	_____
<i>Smoke</i>	_____	_____
<i>Foods</i>	_____	_____
<i>Other</i> _____		

9. Do you have asthma?

Yes *No*

10. Do you have difficulty paying attention in class?

Often *Sometimes* *Rarely* *Never*

11. Do you have difficulty completing homework assignments?

Often *Sometimes* *Rarely* *Never*

12. How often do you think illness interferes with your performance in school?

Often *Sometimes* *Rarely* *Never*

13. When you play sports or other outdoor activities, how often do you experience the following, either while playing or afterwards?

	Always	Sometimes	Rarely	Never
<i>Runny nose</i>	_____	_____	_____	_____
<i>Stuffy nose</i>	_____	_____	_____	_____
<i>Watery eyes</i>	_____	_____	_____	_____
<i>Itchiness</i>	_____	_____	_____	_____
<i>Coughing</i>	_____	_____	_____	_____
<i>Wheezing</i>	_____	_____	_____	_____
<i>Earache</i>	_____	_____	_____	_____
<i>Tiredness</i>	_____	_____	_____	_____

14. How often do the following symptoms keep you from participating in activities such as sports, the school play, or band?

	Often	Sometimes	Rarely	Never
<i>Runny nose</i>	_____	_____	_____	_____
<i>Stuffy nose</i>	_____	_____	_____	_____
<i>Watery eyes</i>	_____	_____	_____	_____
<i>Itchiness</i>	_____	_____	_____	_____
<i>Coughing</i>	_____	_____	_____	_____
<i>Wheezing</i>	_____	_____	_____	_____
<i>Earache</i>	_____	_____	_____	_____
<i>Tiredness</i>	_____	_____	_____	_____

15. How often do you have difficulty sleeping?

Often *Sometimes* *Rarely* *Never*

16. How often do you feel tired during the day?

Often *Sometimes* *Rarely* *Never*