

Indoor Air Quality (IAQ) Questionnaire

Your input is important. In order to help us investigate and resolve your IAQ concerns, please complete and return this questionnaire.

Name: _____ Date: _____
School: _____ FISH / Room #: _____

Problem/Complaint Information:

Briefly describe the nature of your IAQ problem or complaint: _____

1. Room Comfortable:

(a). Temperature generally comfortable (between 72F and 78F)?

YES NO

If no explain: _____

(b). Humidity is generally acceptable (between 30% and 60% RH)?

YES NO

If no explain: _____

(c). Air flowing from air conditioning without obstruction?

YES NO

(d). Windows and doors are operable and kept closed?

YES NO

(e). Odors in room? Yes____ No____

YES NO

If yes explain: _____

2. General Cleanliness:

(a). Classroom appearance clean and acceptable?

YES NO

(b). Classroom dusted / vacuumed thoroughly and regularly?

YES NO

(c). Flooring cleaned on a regular basis?

YES NO

(d). Air conditioning supply and return grills clean?

YES NO

(e). Ceiling tiles and fixtures near air conditioning supply grills clean?

YES NO

(f). Is the Room free of excess stored papers, boxes, books?

YES NO

Cluttered rooms make it hard for custodial staff to clean the rooms properly, seldom used stored papers, books, and boxes retain moisture and odors in rooms.

3. Drain Traps in the classroom:

(a). Is water run in sinks at least once per week?

YES NO N/A

(b). Is water poured into floor drains at least once weekly?

YES NO N/A

Drain traps, if present, can become a problem, when the water in the traps evaporates, sewer gas may enter the classroom. Pouring a quart of water in floor drains and sinks weekly will keep the traps wet, and prevent sewer gas from entering the classroom.

4. Water Intrusion in Room:

(a). Are there any stained or discolored ceiling tiles?

YES NO

(b). Are there any water damaged or stained wall materials?

YES NO

(c). Are the areas around and under sinks free of leaks, or water damage?

YES NO N/A

Symptom Information:

5. Are you experiencing any of the following symptoms? (check all that apply)

(a). Sore / Itchy throat?

(b). Sneezing?

(c). Headache?

(d). Itchy eyes?

(e). Sinus trouble?

(f). Skin Irritation?

(g). Problem w/contact lenses?

6. When did the symptoms begin? _____

7. When are they worst? _____

8. What do you think is the most likely cause of these symptoms? _____

9. Are there any areas in the building where you do not have these symptoms? _____

Additional Information:

10. Do you have any additional information you would like to share?

(a). About your room's IAQ? _____

(b). Building cleanliness? _____

(c). Building maintenance? _____

(d). Other? _____

****Please return this completed Questionnaire Form to your Principal**