



Torrington Public Schools

JOHN BARLOW
DIRECTOR OF FACILITIES

SUSAN M. LUBOMSKI
SUPERINTENDENT

INDOOR AIR COMPLAINT FORM

Name: _____ Date: _____

School Name: _____

Room Number: _____ Date/s of Symptoms: _____

Symptoms: _____

Timing: When did symptoms start, and what has helped symptoms to become better or worse?

Has this been reported to administration? Y or N

Have you been seen by a Doctor? Y or N

355 MIGEON AVENUE
TORRINGTON, CONNECTICUT 06790
www.torrington.org • (860) 489-2327 • fax (860) 489-0726

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