Division of Special Education and Special Services
Health Services Department

Allergy, Asthma, Medical Condition Questionaire

(Questionario sobre Alergia, Asma eh otros Condiciones Medicas)

School Year:_________________

Student Name:___________________________________ Age: _______ Grade:____________
(Nombre del Estudiante) (Edad) (Grado)

Does your child have (Tiene su hijo/a):
Asthma (Asma): Yes (Si): ______ No:_______
Food Allergies (Alergias a Comida) Yes (Si)_____ No:________

If yes, to what? (Porfavor explique):____
____

Serious Illness: Yes (Si):__________ No:__________
(Condicion de Enfermedad) If yes, please explain (Porfavor enlistelo):____
____

Medications that we need to be aware of? (Algo mas que necesita informarnos?)
Yes (Si):__________ No:_______
____
____

Is there anything else you would like to make us aware of regarding your child?(Algo mas que necesita informarnos?)____
____

____ ___________________
Parent/Guardian Signature (Firma de los Padres/Tutor) Date (Fecha)

In the event that health care and/or medication administration is to be provided by the nurse and/or designated trained personnel, a Medication Form must be completed.