



Activity restrictions specified by MD (note required) \_\_\_\_\_

### **Hospitalizations**

Has your child ever been hospitalized for any reason? Yes \_\_\_\_\_ No \_\_\_\_\_

Reason for hospitalization \_\_\_\_\_ How many days? \_\_\_\_\_ Year \_\_\_\_\_

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### **Asthma**

Has your child ever had asthma? Yes \_\_\_\_\_ No \_\_\_\_\_

How often does your child have asthma attacks? \_\_\_\_\_

What triggers your child's asthma? \_\_\_\_\_

Has your child used asthma medicine in the past 2 years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate medicine used \_\_\_\_\_

### **Allergies**

To food? Yes \_\_\_\_\_ No \_\_\_\_\_ To medicine? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list things child is allergic to and indicate symptoms:

\_\_\_\_\_

Anaphylaxis? Yes \_\_\_\_\_ No \_\_\_\_\_ Epipen? Yes \_\_\_\_\_ No \_\_\_\_\_

### **Medications**

Does your child take any prescription medicine at home? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list medicine(s) \_\_\_\_\_

Will your child be taking prescription medicine at school? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what medicine(s)? \_\_\_\_\_

Parents/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

**I GIVE PERMISSION TO SHARE THIS INFORMATION WITH STAFF MEMBERS INVOLVED IN MY CHILD'S CARE AND EDUCATION.**

Parents/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_