



Allergy, Asthma, Medical Condition Questionnaire
(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.**