

3. Has your child had an allergic reaction to any foods? No Yes
Please describe what happened. _____

4. Has your child ever had an adverse reaction to an insect sting? No Yes
Please describe what happened. _____

5. Does your child have asthma ? No Yes

A. What type of asthma (allergic, exercise induced, etc.)?

B. Your child's best Peak Flow reading _____

C. Please list any medication(s) your child takes for asthma and the frequency it is taken.

D. Medication History

Does your child take medication on a daily basis? No Yes

Please list any medications taken and describe what the medication is for. _____

Has your child ever had a serious illness ? No Yes
What and when ? _____

E. Social History

Have there been any changes in your family during the past year, such as:

1. Separation, divorce, or remarriage? No Yes

2. Death or serious illness? No Yes

3. Any other situation which may affect your son/daughter? No Yes

If yes, please explain _____

F: Miscellaneous

Please list any condition your child may have which might limit his/her activities in school. Please include any other comments you think might be helpful.

Thank you for completing this form.