Dear Parents,

In an effort to upgrade our student records, we ask you to complete the following **ONLY** if your child:

- suffers from asthma
- suffers allergic reactions to such things as peanuts, fish, bee stings etc.
- is diabetic
- has any other medical conditions we should know about.

**Child's Name**: _____ **Class**: _____

| ASTHMA | |
|---|---|
| SYMPTOMS | |
| ACTION TO BE TAKEN | |

| ALLERGIES | |
|---|---|
| ALLERGIC TO | |
| SYMPTOMS | |
| ACTION TO BE TAKEN | |

| DIABETIC | |
|---|---|
| SYMPTOMS | |
| ACTION TO BE TAKEN | |

| OTHER MEDICAL CONDITIONS |
|---|
| |

*If you have written instructions from a doctor or specialist in regard to any of the above, please forward a copy with this questionnaire (unless you have already done so).*

**Signature of Parent / Guardian:** _____ **Date:** _____

**Printed Name of Parent /Guardian:** _____