

Name \_\_\_\_\_ Age \_\_\_\_\_

**MEDICAL CONCERNS  
Aerosol Treatment**

My child has been using aerosol treatments for \_\_\_\_\_.

My child uses aerosol because \_\_\_\_\_

\_\_\_\_\_.

Please fill out the time schedule for when aerosol treatments are to be given.

<b>Times</b>	<b>How long?</b>	<b>Amount?</b>	<b>Side effects?</b>

**Special Concerns/ Instructions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Please note: This form is for use of gathering additional information and does not replace any required licensing forms.**