York Catholic High School

601 E. Springettsbury Avenue, York, PA 17403
717.846.8871 ♣ www.yorkcatholic.org

ALLERGY QUESTIONNAIRE

Student's Name ____ Grade ______

1. What is your child allergic to? ____
2. At what age was your child diagnosed with the allergy? ______________________
3. What symptoms of the allergy does your child have? (rash, hives, shortness of breath, etc.)

   ____

4. What causes the symptoms related to your child's allergy? *(please check all that apply)*

   ❑ Ingestion (eating or drinking the substance) ❑ Touching the allergen ❑ Inhaling the allergen

   Please explain____

5. What medications have been used to treat your child's allergic reaction?

   ____

6. Will your child be keeping an EpiPen at school? ❑ Yes ❑ No

   If yes, where will the EpiPen be kept? ❑ Nurse's Office ❑ On Student ❑ Both
   (if other than the Nurse's Office, doctor must complete Consent to Carry/Self-Administer form)

7. Has your child ever needed to use an EpiPen? ❑ Yes ❑ No

   If yes, please explain the incident ______________________________________

   ____

8. Will your child need to sit at a nut-free lunch table? ❑ Yes ❑ No
9. Does your child have asthma? ❑ Yes ❑ No

   If yes, please list asthma medications ___________________________________

10. Other comments, concerns:

    ____

    ____

______________________ ________________________ __________
Parent's Printed Name *Parent's Signature* *Date*