

ALLERGY QUESTIONNAIRE

Student's Name _____ Grade _____

What is your child allergic to? _____

At what age was your child diagnosed with the allergy? _____

What symptoms of the allergy does your child have? (rash, hives, shortness of breath, etc.)

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 _____

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

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)

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

If yes, please explain the incident _____

Will your child need to sit at a nut-free lunch table? Yes No

Does your child have asthma? Yes No

If yes, please list asthma medications _____

Other comments, concerns: _____

Parent's Printed Name

Parent's Signature

Date