ALLERGY QUESTIONNAIRE

Student's Name______________________________________**Date of Birth**_______________

1. Does your child have a diagnosis of an allergy from a healthcare provider?
___Yes ___No

2. History and Current Status

A. What is your child allergic to?

____Peanut ____Insect Stings
____Eggs ____Fish/Shellfish
____Milk ____Chemicals
____Latex ____Soy
____Tree Nuts
____Other _______________________________

B. Age of student when allergy was first discovered: ________
C. How many times has the student had a reaction? ___________
D. Explain past reaction(s):____
E. Symptoms:____

3. Trigger and Symptoms

A. What are the early signs and symptoms of your student's allergic reaction?

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B. Please check the symptoms that your child has experienced in the past:

Skin: ____Hives ____Itching ____Rash ____Flushing ____Swelling
Mouth: ____Itching ____Swelling
Abdominal: ____Nausea ____Cramps ____Vomiting ____Diarrhea
Throat: ____Itching ____Tightness ____Cough ____Hoarseness
Lungs: ____Shortness of Breath ____Repetitive Cough
Heart: ____Weak Pulse ____Loss of Consciousness

4. Treatment

A. Has your child ever required an EpiPen? ____Yes ____No
B. How effective was your student's response to treatment? ______________________

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Parent/Guardian Signature____ Date______________

School Nurse Signature____ Date______________