Allergy Information for School

Student Name: _____ DOB: _____ Grade: _____

Parent/Guardian: _____ Phone(s): _____

Physician treating allergy: _____ Phone: _____

1. Do you or your doctor think your student's allergy may be ***life-threatening*** (a reaction could affect breathing or blood pressure)? ☐ Yes ☐ No
2. Has your student ever needed a treatment at a clinic or hospital for an allergic reaction? ☐ Yes ☐ No
3. Please list all things that have caused an allergic reaction:

   _____

   _____

4. What has to happen for your student to have a reactions (check all that apply)?

   ☐ Eat the food ☐ Touch the item/food ☐ Smell the item/food ☐ get stung

5. How many times has your student had a reaction? _____ When was the last reaction? _____
6. Are the allergic reactions: ☐ staying the same? ☐ getting better? ☐ getting worse?
7. What are the symptoms of your child's allergic reaction? (check all that apply, including things your student might say)

   ☐ Feels scared, "something bad is going to happen
   ☐ Swelling of face, hands, or feet
   ☐ Cough
   ☐ Nausea, stomach cramps, vomiting, diarrhea
   ☐ Hives, itchy rash
   ☐ Difficulty breathing
   ☐ Wheezing
   ☐ Passing out
   ☐ Itching or swelling of lips, tongue, or mouth
   ☐ Other: _____

8. How quickly to symptoms appear, after exposure to the allergen?

   ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

9. What treatment has your doctor recommended for an allergic reaction?

   _____

   _____

10. Have you used the medicine? ☐ Yes ☐ No
11. Does your student know how to use the medicine? ☐ Yes ☐ No
12. What can/should we do at school to help your student avoid allergens? _____
13. Does your student understand how to avoid allergens? ☐ Yes ☐ No
14. Other information: _____

    _____

Parent/Guardian Signature: _____ Date: _____