Allergy History Form

For all students, 1 form per child

Student Name_____ Class_____ Date_____

Please provide us with any pertinent information about all known allergies your child may have by answering the following questions (please circle Yes OR No):

Does your child have a known allergy to any of the following?
For any Yes response, please list specific allergens and type of reaction.

Yes/No foods

_____

Yes/No Insects

_____

Yes/No seasonal (pollens)

_____

Yes/No mold

_____

Yes/No environmental (chemicals/smoke/dust, etc)

_____

Yes/No Latex (balloons, band aids, gloves, etc)

_____

Yes/No medications

_____

1. When and how did you first become aware of this allergy?
   _____
2. When was the last time your child had a reaction?_____

3. Please describe the type of reaction your child has (signs and symptoms and severity)
   _____
   _____
4. Does your child take any daily medications related to allergies? Yes/No
   If Yes, Please list all allergy medications:
   _____
   _____

If your child has medications related to potential reactions for any of the listed allergies, please provide an Emergency Action Plan completed by a licensed medical provider to be kept on file at the school. Please provide the medications that the doctor has prescribed so that these medications may be administered in case of an allergic reaction at school. Please verify all emergency contact information is up to date and on file at the school office.

If you have specific steps you would like us to take if your child is exposed to this allergen while at school, please describe:

_____
_____
_____

Signature of Parent

Or Guardian: _____Date:_____

Printed Name: _____