Allergy Information Form

Contact Information

Student's Name:_____ DOB:_____

Parent/Guardian:_____ Phone:_____

Allergy Physician:_____ Phone:_____

Allergy Information

1. Has your child been diagnosed with allergies/anaphylactic reactions by a healthcare provider?

   ☐No ☐Yes If yes, at what age?_____

2. Please list all of your child's allergies, including foods:_____

   _____

   _____

3. Is it necessary to avoid physical contact or inhalation of allergen? ☐No ☐ Yes

4. How soon after exposure does your child react?_____

5. What are the early signs and symptoms of your student's allergic reaction? *(Be specific, include things the student might say)*.

   _____

   _____

   Mark any previous symptoms your child has had:

   ☐Rash ☐Vomiting ☐Diarrhea ☐Swelling of lips or tongue ☐Shortness of Breath

   ☐Difficulty Swallowing ☐Fainting ☐Wheezing

6. How responsible is your child in preventing and responding to an allergen(s)? (Check all that apply)
   ☐My child know what allergens(s)/foods to avoid.
   ☐My child knows to ask about ingredients in foods, if unsure.
   ☐My child knows to immediately tell an adult if exposed to an allergen.
   ☐My child knows to always have someone go with them for help if having an allergic reactions or after having administered their emergency medication.
   ☐My child can give their own infection with a an epinephrine auto-injector if prescribed by a healthcare provider.
   ☐Other:_____

7. Does your child wear a medic alert? ☐No ☐ Yes

8. Does your child require emergency medication at school? ☐No ☐ Yes
   If yes, indicate medication needed: ☐Epinephrine auto-injector ☐Benadryl ☐Other:_____