Allergy Questionnaire

Student Name		Date of Birth		School Year	
School	Immaculate Conception School	HR/Grade			
Parent/Guardian		Relationship		Phone	
Parent/Guardian		Relationship		Phone	
Emergency Contact		Relationship		Phone	
Healthcare Provider		Phone		Fax	

This information will provide the school nurse with a better understanding of the child's needs. This questionnaire needs updated and completed each school year.

Has this child been diagnosed with allergies/anaphylactic reactions by a healthcare provider? ☐ Yes ☐ No

Note: Bring medical documentation to the school nurse. **AFTER** the nurse has received documentation from the child's **healthcare provider,** school staff will be notified of the allergies and emergency plans.

List all allergies, including foods	Child reacts to allergen if: Circle	Describe allergic reaction:	How long does it take to react?
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		
	swallows touches inhales		

Prevention: **How does this child prevent and respond to an allergic reaction? (check all that apply)**

☐ The child knows what to avoid
☐ The child asks about ingredients in food, if unsure
☐ The child tells other about his/her allergies
☐ The child will immediately tell an adult if exposed to an allergen
☐ **The child wears an identifying tag or bracelet alerting others to the allergy**
☐ Other:

Allergy Response:

Has this child ever needed to use an epinephrine auto-injector (Epipen): ☐ Yes ☐ No If yes, date of last injection: _____

Are medications needed AT SCHOOL? ☐ Yes - List ☐ No	**Dose:**	**Time:**
IF medication is needed at school, parent must complete the Medication Authorization Form and bring the medication to school.		
Allergy medication AT HOME: ☐ Yes - List ☐ No	**Dose:**	**Time:**

Any other information or chronic health problems that would be helpful to know?

Parent/Guardian Signature _____ **Date** _____

RETURN TO SCHOOL NURSE IMMEDIATELY