Allergy Questionnaire

Child' Name:_______________________________ Birthdate:_______________

Has your child been diagnosed as having allergies by a medical professional?
Yes /NO If so, who is the Doctor? __________________ Phone #_____________.

When was child diagnosed as having allergy/allergies? _______________________.

Has your child been in the Emergency room for this? Yes /NO When:__________

Has child been hospitalized for serve allergy / allergies? Yes / NO When: ________

Does your child take <u>currently</u> prescribed medication for allergy/allergies? Yes / NO If so, list medication and when given: _________________________________
____.

What does your child have allergy/ allergies to? Please list: ____________________
____.

Can you identify any triggers that cause an allergy attack: example: insects, pollen, seasonal changes, etc.____
____.

What are some Signs & Symptoms your child may exhibit if having an allergy problem? Please explain: ____
____.

Will child need an Epi Pen or Benadryl or any medication keep at school? Yes /NO
***(If yes, have doctor complete permission form for Prescribed or Over-the-Counter Medications) and do health care plan**

Parent / Guardian Signature__________________________________Date:______