STUDENT ALLERGY SURVEY

TO PARENTS/GUARDIANS:

This survey is designed to obtain information concerning life-threatening allergies.

_____
Student's Name

1. Does you child have a life-threatening allergy? ____ yes ____ no

2. Does your child have any allergies that produce any of the following symptoms following exposure to a particular material?
   - A. difficulty breathing? ____ yes ____ no
   - B. fainting or collapse ____ yes ____ no
   - C. swelling of the tongue, lips or face ____ yes ____ no
   - D. other (specify) ____ yes ____ no

   _____

3. Have any of the symptoms referred to in question 2 occurred after:
   - A. eating particular food ____ yes ____ no
   - B. receiving an insect bite ____ yes ____ no
   - C. receiving a sting ____ yes ____ no

IF YOU RESPONDED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE CONTINUE

4. Has your child been seen by a health care provider for treatment of an allergic reaction? ____ yes ____ no

5. Has your child been tested for allergies? ____ yes ____ no

   If yes, indicate types of tests and results or attach a copy

_____

_____

_____

6. Have you been told by your child's health care provider that your child requires an emergency medical kit available in the school? ____ yes ____ no

7. What food, drugs or materials must your child avoid due to allergies?

   _____

8. What foods must your child avoid for other reasons? Please explain.

   _____

   _____

9. Name of child's health care provider _____

I agree that this information will be shared, as necessary, with the staff of the school and health care systems.

_____ _____
Parent/Guardian/Nurse Manager Signature Date