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