Allergy Questionnaire

Child's Name: _____Date of Birth: _____Grade_____

What is your child allergic to? Is the allergy from eating only or is contact, touching, or smelling a concern?

Describe the reaction your child had i.e. rash, itching, swelling, cough, trouble breathing, nausea.

Has your child been tested for allergies? List the allergens he/she is positive for.

When did your child have the last allergic reaction? To what was it attributed?

How was it treated? Medications given? Was a Hospital visit needed?

Please list the medications your child is presently taking. Include over the counter meds.

Does your child have an Epinephrine auto-injector? YES NO

□ **My child needs to sit at the nut free table**

□ **My child does not need to sit at the nut free table**

Parent Signature: _____Date: _____