East Side Union High School District
Allergy Questionnaire

Student:	**DOB:**	**Date:**
School:	**Grade:**	**Asthma:** ☐ Yes ☐ No

Information provided by:

1. **Does your child have allergies that may present a problem during the school day?** ☐ **Yes** ☐ **No**

2. **What is your child allergic to?**

3. **Describe the symptoms of your child's allergic reaction:**

4. **My child takes medication at home:** ☐ **As Needed** ☐ **On a Regular Basis**
   Please list medications:

   ☐ **No, my child does not take medication for allergies.**

5. **Is there a need to keep medications at school?** ☐ **Yes** ☐ **No**
   ***** provide a *School Medication Administration Authorization* form completed by a physician and a guardian for **each** medication. If your child needs to carry emergency medication at school **also** provide an *Authorization to Carry and Self-Administer Emergency Medication on Campus* form completed by a physician and a guardian.

6. **Does your child experience severe allergic reactions (anaphylaxis)? Examples of some symptoms of severe allergic reactions are: difficulty breathing, swelling of the lips, eyes, or throat.**
   ☐ **Yes** ☐ **No**

7. **Does your child have emergency epinephrine (example: Epi Pen) prescribed?** ☐ **Yes** ☐ **No**
   *****If you answered **Yes** to either 6 or 7 please complete the rest of this questionnaire. If you answered **No** to both 6 and 7 please sign the form and submit it to the health office at your child's school.

8. **List all allergies or factors that may cause anaphylaxis (severe allergic reaction):**

9. **Check all reactions your child has experienced:**

☐ Hives	☐ Diarrhea	☐ Repetitive cough
☐ Itching of skin, mouth or throat	☐ Repetitive vomiting	☐ Dizziness
☐ Swelling of tongue and/or lips/mouth	☐ Wheezing	☐ Change of skin color (pale, blue)
☐ Nausea	☐ Throat tightness	☐ Faint, weak pulse
☐ Abdominal cramps	☐ Shortness of breath	☐ Loss of consciousness
	☐ Trouble swallowing	☐ Other:

10. **History of past severe allergic (anaphylactic) reactions:**
    Date of last reaction?

_____ _____
Parent/Guardian Signature Date

Please return completed form to school Health Office. 5-15-19