Hempfield School District
Landisville, Pennsylvania
Allergy Questionnaire

Student: _____ **DOB:** _____ **Teacher:** _____ **Grade:** _____

Name of Physician treating the allergy: _____ **Phone #:** _____

1. My child is allergic to: _____

2. My child has asthma? ☐Yes ☐No

3. Briefly indicate symptoms of your child's allergy:

☐Tingling or swelling of lips, tongue mouth	☐Itching	☐Hives
☐Swelling of face or extremities	☐Itchy rash	☐Nausea
☐Abdominal cramps	☐Vomiting	☐Diarrhea
☐Tightening of throat	☐Hoarseness	☐Hacking cough
☐Weak or thready pulse	☐Low blood pressure	☐Fainting
☐Blueness	☐Pale	

☐Other (please specify) _____

4. Does your child require medication during a reaction? ☐Yes ☐No If you checked "Yes" please list.

_____

_____

Requests for Administration of Medication forms signed by the parent and physician are required for all medications given at school, including Epipen or Benadryl.

5. When was your child's last allergic reaction? _____

6. Has your child been to the doctor or an emergency room due to an allergic reaction? ☐Yes ☐No

7. Does your child require medical care after a reaction? ☐Yes ☐No
IF you checked "yes" you are encouraged to alert all other school personnel (transportation department, child nutrition department, etc.) that have contact with your child, so that they are aware of the medical care that is required after a reaction.

8. What steps do you want school personnel to take if your child develops an allergic reaction? _____

_____

You are encouraged to alert all other school personnel (transportation department, child nutrition department, etc.) that may have contact with your child, so that they are aware of your child's diagnosis and the treatment that may be required during school hours.

Parent signature: _____ **Date:** _____

10/09