**South Brunswick Township Public Schools**

## ALLERGY QUESTIONNAIRE

School _____ School Year _____

Student's Name_____ Date of Birth_____ Grade _____

Does your child see an allergist for their allergies?

_____ Yes - Physician's name_____Last visit _____

_____ No

What is your child allergic to? Please check all that apply.

_____ Medicine Please specify _____

_____ Food Please specify _____

_____ Bee/Insect Please specify _____

_____ Seasonal Please specify _____

_____ Environmental Please specify _____

_____ Other Please specify _____

Describe the reaction or symptoms your child exhibits when having an allergic reaction.

_____

_____

Does your child take any medication for his/her allergy? _____YES _____NO

| Name of Medication | Dosage | When used (daily, twice daily, as needed) |
|---|---|---|
| | | |
| | | |
| | | |

Is there a need to keep medication in school?

_____ Yes - Please discuss with school nurse_____

_____ No

Has your child ever been hospitalized, gone to the emergency room, or visited the doctor due to an allergic reaction?

_____ Yes - Please explain_____

_____ No

Please provide any additional information you think would be helpful for the school nurse regarding your child's allergy prevention or emergency treatment.

_____

_____

_____ _____

Parent/Guardian Name Printed Phone Number

_____ _____

Parent/Guardian Signature Date

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