South Brunswick School District

ALLERGY QUESTIONNAIRE

Student's Name _____ Date of Birth _____ Grade_____

Parent/Guardian's Name(s) _____Telephone Number _____

Does your child have any allergies? NO - Please DO NOT CONTINUE and sign below

Parent/Guardian Signature _____

YES, please answer the following questions:

1. 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 _____

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

   _____

   _____

3. Does your child take any medication for his/her allergy: YES NO

   Please list all medications:

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

4. Is there a need to keep medication in school? NO____YES, Please discuss with the School Nurse.
5. Are there any limitations/restrictions to physical activities at school due to allergies? NO _____

   YES, please explain and provide a doctor's note stating limitation and duration

   _____

   _____

6. Has your child ever been hospitalized, gone to the Emergency Room, or visited the doctor due to an allergic reaction? NO _____

   YES, please explain _____

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

   _____

_____ _____ _____

Print Parent/Guardian Name Parent/Guardian Signature Date