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.

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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.

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______________________ Parent/Guardian Name Printed

______________________ Phone Number

______________________ Parent/Guardian Signature

______________________ Date

Rev. 2-16-07