

## ALLERGY ASSESSMENT

School Year: \_\_\_\_\_

ID Number : \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name, First Name Month Day Year

Parent/Guardian: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Parent/Guardian printed name Teacher's Name

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
area code + number area code + number area code + number

According to your student's health records, s/he has a problem with allergies. It would be helpful if you would provide us with more information by completing this form, and returning it to the school nurse.

Sincerely,

\_\_\_\_\_  
School Nurse Date: \_\_\_\_\_  
Month Day Year

Physician's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
Physician's printed name Medical Group/Clinic area code + number

Allergies are no longer a problem for my student. Sign below and return this form to the School Nurse.

When is your student most affected by allergies? (Check all that apply)

Seasonal -  Fall  Winter  Spring  Summer

Exposure-  Eaten  Touched  Inhaled

What specific things is he/she allergic to? (Check all that apply)

Milk  Bee Stings  Peanuts/Tree Nuts, please list types: \_\_\_\_\_  
 Drugs  Dust  Grasses/Trees, please list types: \_\_\_\_\_  
 Mold  Pollen  Animal dander  
 Food, please list types: \_\_\_\_\_  Other: \_\_\_\_\_

Comments: \_\_\_\_\_

The common symptoms of allergy that your child experiences are: (check all that apply)

Tired  Sneezing  Persistent cough  Wheezing breath sounds  
 Pale  Rash/Hives  Dark circles / bags under eyes  Breathing through mouth  
 Irritability  Hearing problems  Swelling of exposure site  Breathing problems  
 Anaphylactic Shock reaction  Headaches  Stuffy, runny, itchy nose  Diagnosis of ASTHMA  
 Other: \_\_\_\_\_  Itchy, watering eyes

Last allergic reaction was: \_\_\_\_\_ Was Emergency Care required?  YES  NO

How does your child's allergic condition affect his/her school performance, participation and attendance : \_\_\_\_\_

Does your child know what his/her allergy is and what to avoid?  YES  NO

How often does he/she see the physician because of allergies? \_\_\_\_\_

What medication does he/she use?

Name \_\_\_\_\_ Name \_\_\_\_\_  
Dose \_\_\_\_\_ Dose \_\_\_\_\_  
Frequency \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Name \_\_\_\_\_  
Dose \_\_\_\_\_ Dose \_\_\_\_\_  
Frequency \_\_\_\_\_ Frequency \_\_\_\_\_

Will it be necessary for this student to have medication available here at school for the allergic condition?

No  Yes. If yes, please contact the nurse for assistance as soon as possible.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Signature Month Day Year