



ALLERGY INFORMATION FORM

(Completed by parent or guardian)

Student Name _____ Birthdate _____

Teacher _____ Grade _____

Allergic to: (list all)	Reaction (list for each allergen)

Yes___ No___ Are your child's allergies life-threatening?

Yes___ No___ Does your child take medications for allergy management?

List **all** medications used to treat your child's allergies (include over-the-counter and prescriptions):

<u>Medication</u>	<u>Dose</u>	<u>Times Given</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes___ No___ Has an epi-pen been prescribed for your child?

Yes___ No___ Has your child ever had allergy shots? When? _____

How else are your child's allergies treated? _____

Describe your child's understanding of his/her allergies _____

Yes___ No___ Do you want classroom families to be notified that a child in the class has a severe allergy?

How does your child get to and from school? Walks___ Rides bus number___ Daycare van___

Drives self___ Other___

What needs to be changed about your child's school day or environment to keep your child safe?

What accommodations are needed for your child (snack, class parties, lunch, recess, PE, field trips, emergency evacuations)?

Signature of Parent or Guardian _____ Date _____