EAST ROCKAWAY PUBLIC SCHOOLS
EAST ROCKAWAY, NEW YORK
ALLERGY QUESTIONNAIRE

Child's Name: ____
School:_________________ Date:__________ Grade: __________ DOB: __________________

School health records indicate your child may have allergies. For some students, this can be a serious problem. Please help us understand your child's situation and to have the most current health information on your child by completing and returning this form to the school health office as soon as possible.

l. What is your child allergic to? Please check all that apply.
____Drug ____Food ____Seasonal ____Bee sting/insect ____Other
Please specify:____

2. Does your child take medication for this allergy?
____Daily ____As needed ____No medication is needed
Please list medications:
____

3. Is there a need to keep medication at school? ____Yes* ____No
(*If yes, please speak with the school nurse.)

4. Are there any limitations/restrictions of physical activities at school that are required by your physician due to allergies?
____ Yes ____ No
Please specify:
____

5. When was the most recent episode of an allergic reaction? Please specify date and details:
____

6. What are the symptoms your child exhibits when having an allergic reaction?
____
____

7. Has your child ever been hospitalized, gone to the emergency room, or visited the doctor due to an allergic reaction?
____Yes ____No
If yes, please explain:
____
____

Parent/Guardian Printed ______________________________________

Signature Parent/Guardian___________________________________ Date: _________________

This information will be shared with school staff on a need to know basis to protect the safety of the student