

## Office of the School Nurse

Date \_\_\_\_\_

**MEMORANDUM FOR:** Parents/Sponsor of: \_\_\_\_\_

**SUBJECT:** Allergies

An indication was made on your child's Health Record that she/he has allergies. To better assist your child at school, please complete the questionnaire below and return it to the School Health Office. If you have any questions call "insert name and school phone number".

**1. What are your child's allergies?**

\_\_\_ Animals \_\_\_ Bees \_\_\_ Drugs \_\_\_ Environmental \_\_\_ Food \_\_\_ Insect bites \_\_\_ Wasps

**Indicate specific allergens** \_\_\_\_\_

**2. What kind of reaction does your child experience?**

Localized swelling \_\_\_ Shortness of breath \_\_\_

Loss of consciousness \_\_\_ Hives (urticaria) \_\_\_

Other \_\_\_\_\_

**3. How has your child been treated after a reaction?**

a. Received an injection: NO YES Specify: \_\_\_\_\_

b. Received oral medication: NO YES Specify: \_\_\_\_\_

c. Been hospitalized: NO YES Specify: \_\_\_\_\_

**4. Does your child carry an Epi-Pen, ANA-Kit or other medicine with her/him at all times?**

NO YES

**5. Do you keep an Epi-Pen, ANA-Kit or other medicine at home?**

NO YES

***If you answered YES to either of the last two questions, the school should also have medication for your child. Bring the completed "Medication During School Hours" form (attached) and the labeled medication container to school. If your child must also carry the medication with him/her at school, please provide a completed "Permission for Student to Retain Control of Medication" Form.***

\_\_\_\_\_  
Parent/Sponsor Signature

\_\_\_\_\_  
Date