



Allergy Care Questionnaire

Student's Name: _____ Class: _____

Allergy: _____ / _____
: _____ / _____ - _____

Please describe your child's allergy or allergies:

Is your child's allergy (or allergen) airborne or contact or both?

Has your child ever had a reaction to the allergy or allergens?

- ___ No, my child has not had a reaction.
- ___ No, but has been tested by a physician and tested positive.
- ___ Yes, what was the reaction and how was it treated?

Do you let your child eat items that are processed in the same factory as your child's allergy? **For example:** if you child is allergic to tree nuts, do you let them eat items processed in the facility with tree nuts?

If your child has an allergic reaction at preschool, what is the best way to reach you?

Physician and Parent has discussed and agreed upon this questionnaire:

Parent Initials: _____ / Date: _____ Physician's Initials: _____ /Date: _____

