LHSA
A Community Action Agency

EARLY HEAD START/HEAD START
ALLERGY/PARENT QUESTIONNAIRE

Child's Name _____ Teacher _____ Room _____

Dear Parent/Guardian:

You have indicated on your child's emergency card or health history that your child has allergies. Please complete this form and return it to school by _____.

1. Has a doctor diagnosed your child's allergies? Yes ____ No ____

2. Which of the following is your child allergic to? Please list.
   Foods _____
   Environmental (trees, pollen, etc.) _____
   Animals _____
   Medications _____
   Other _____

3. What happens to your child during an allergic reaction? _____
   _____

4. Does your child need special care during an allergic reaction? Yes ____ No ____
   If yes, what care does your child need? _____

5. Is your child currently taking medications for allergies? Yes ____ No ____
   If yes, please list all medications. _____

6. Does your child need medication at school for treatment of allergies? Yes ___ No ___

****If your child needs medical attention or medication for an allergic reaction while at school, you and your child's physician must complete and sign an ALLERGY ACTION PLAN.**

7. Is there anything else we need to know about your child's allergies? _____
   _____

8. Parent/Guardian Signature _____Date: _____

Thank you for your cooperation.

_____ _____ _____
Head Start/Early Head Start Staff Phone # Date

Reviewed 1-2020