MARQUARDT
SCHOOL DISTRICT 15

ANNUAL ALLERGY HISTORY FORM

Student Name _____ School Year _____

School Name _____ Grade _____

According to health questionnaire completed for your child, they are allergic to:

_____

Please provide nursing staff with specific information regarding your student's allergy and health needs.

1. At what age did your child experience their first allergic reaction? _____
2. Please indicate (X) symptoms of allergic reaction your child has experienced in the past

___ Itching, tingling, or swelling of lips, tongue, mouth

___ Hives, itchy rash, swelling of the face or extremities

___ Nausea, abdominal cramping, vomiting, diarrhea

___ Throat tightening, hoarseness, hacking cough

___ Shortness of breath, repetitive coughing, wheezing

___ Fainting, pale, blueness

___ Other (please describe)

_____

3. Has your child seen a doctor for this allergy? _____
4. Has your child been seen in the emergency room due to allergic reaction, if yes, what medication was given?

_____

5. When was the last time your child had an allergic reaction? _____
6. How do you treat allergic reactions at home? _____
7. Has your child been prescribed an epinephrine auto-injector (Epi-pen™ or other)? _____
8. Does your child know how to use the auto-injector independently? _____
9. When an allergic reaction has occurred in the past, please indicate (X) the way your child was exposed to the allergen:

___ Eat/Consume ___ Touch ___ Inhalation ___ Other (please describe)

_____

Signature Parent/Guardian _____ Date _____

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