ALLERGY QUESTIONNAIRE

Monticello Public Schools Health Services

Student Name: _____ Grade/Teacher _____ /_____
Child diagnosed by MD (name):_____ Clinic/Telephone:_____/_____

Allergy(ies) to (Check all that apply):

- Nuts (specify)_____
- Peanuts
- Seafood
- Milk
- Eggs
- Latex
- Insect Bites (specify) _____
- Other (specify) _____

Has your child had an anaphylactic reaction? ❑ yes ❑ no Last time reaction? _____
What used to treat?_____
Does your child recognize these symptoms? ❑ yes ❑ no
Does your child know how to avoid causes of allergic reactions? ❑ yes ❑ no
Does your child have asthma? ❑ yes ❑ no Does your child have eczema? ❑ yes ❑ no

Circle the symptoms your child has shown during an allergic reaction:

- Mouth: itching, tingling, or swelling of lips, tongue, or mouth
- Skin: hives, itchy rash, or swelling
- Gut: nausea, abdominal cramps, vomiting, or diarrhea
- Throat: tightening of throat, hoarseness, or hacking cough
- Lung: shortness of breath, coughing, or wheezing
- Heart: weak pulse, dizziness, fainting, or pale or blue skin
- Other:

_____

FOOD ALLERGIES ONLY
Cafeteria Seating (please check one): ❑ Peanut Free Table ❑ Sit with class

Classroom Food Management:
Does your child need special precautions in the classroom in regards to:

1. Snack ❑ yes ❑ no
2. Classroom parties ❑ yes ❑ no
3. Food use in cirriculum ❑ yes ❑ no

If yes to any of the above, please explain _____
Do you believe your child's allergy issues in school need to be addressed in more detail? ❑ yes ❑ no

(If you answer yes to any of the above, the school nurse will contact you.)

Parent(s)/Guardian(s) signature(s): _____ Date:_____