RINGGOLD SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
ALLERGY HISTORY FORM

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Student Name:_____ Birthdate:_____ Grade:_____

1. Known allergies:_____
2. Previous reactions to known allergies:

   _____

   _____
3. Symptoms or reactions from mild to severe (if more than one allergy, please list separately):_____

   _____

   _____
4. Number of past serious reactions:_____
5. Past treatment of reactions from mild to severe and effectiveness of treatment:

   _____

   _____
6. Student's knowledge of symptoms and treatment: _____

   _____

   _____
7. Is student able to avoid allergens (triggers)?_____
8. Is student able to alert others to possible reactions and to assist with treatment?

   _____
9. For food allergies: Can your child sit next to someone eating the food he/she is allergic to? Yes_____ No_____
   Would you like your child to eat lunch at an allergy-free table? Yes____ No____
10. For Elementary Students Only: Would you like a letter sent to other parents/guardians in your child's classroom alerting them to the presence of a child with a food allergy? Yes_____ No_____
11. For Elementary Students Only: Would you like your child's classmates to learn about your child's allergy? Yes_____ No_____

_____ _____

Parent/Guardian Signature Date