WHITE PLAINS CITY SCHOOL DISTRICT
FAMILY INFORMATION CENTER
350 Main Street
White Plains, NY 10601
(914) 422-2038

ALLERGY FORM

Student's Name:		DOB:	

ALLERGIES: Please detail below.

At what age was your child diagnosed with an allergy? _____

Which physician made this diagnosis? Pediatrician/Allergist? _____

Name of current physician? _____ Number? _____

Address: _____

What symptoms led to this diagnosis: _____

_____

Parents should DIRECTLY inform the school nurse if their child has a life-threatening allergy or illness to ensure their safety in school.

Has your child had any of the following?

Skin testing for allergies?	Yes		No	
Blood testing?	Yes		No	
A food challenge?	Yes		No	

Is your child currently taking any medication?	Yes		No		
Name	**Dose**				**Frequency**

How many allergic reactions has your child experienced?
Has an Epi Pen ever been administered to your child?
Has your child ever been hospitalized for an allergic reaction?
Is your child aware of his/her allergies?
Has your child had a reaction at camp?
Do you have any issues or concerns that you would like to share with the nurse?
Does your child have an Epi Pen prescribed for him/her?

Name of Parent/Legal Guardian Signature of Parent or Legal Guardian Date