Pearland Independent School District

Student Allergy History Questionnaire

Student's Name: _______ School _____ Grade: ____

Allergic to: _____

_____

How and when did you first become aware of your student's allergy? _____

_____

_____

When was the last time your child had a reaction? _____

Please describe the signs and symptoms of your student's reaction. _____

_____

_____

What medical treatment has been provided and by whom? _____

_____

_____

Please provide any additional information you would like us to have in the event your student has an allergic reaction at school: _____

_____

_____

_____

_____

Parent/Guardian Signature: _____Print Name: _____

Last revised 05/2025