BRADFORD COUNTY DISTRICT SCHOOLS and
BRADFORD COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES

ALLERGY CONDITION QUESTIONNAIRE/HISTORY

(To be completed by parent)

PLACE I.D. PHOTO HERE

Name: _____**D.O.B.** _____ **School Yr.** _____

Parent: _____Primary Phone # _____

Physician _____ Phone _____

ALLERGY TO: ☐Peanuts ☐Milk ☐Fish ☐Soy ☐Sesame Seed/Sesame Oil

☐Eggs ☐Shellfish ☐Tree Nuts(pecans, walnuts, etc.) ☐Wheat ☐Chocolate ☐Bees ☐Ants

☐Latex ☐Other:_____ Asthma? ☐Yes OR ☐No

Does your child use any of the following for managing allergies? ☐Over the Counter Antihistamine (Example: Benadryl)

☐Epi-pen or Epi-pen Jr If so, is your child trained to use the pen? ☐Yes OR ☐No

When was the last time your child was seen by a physician for this condition(s)? _____

How many times has this student been seen in the emergency room in the past year for this condition(s)? _____

How many times has this student been hospitalized in the past year for this condition(s)? _____

Has this student ever been admitted to an intensive care unit for this condition(s)? _____

How many days would you estimate that this student missed from school or daycare last year for this condition(s)? _____

Allergy Medication	**Amount**	**Delivery Method (by mouth, etc.)**	**How Often**
_____	_____	_____	_____
_____	_____	_____	_____

Control of Environment: (List any environmental control measures, pre-medications, and/or dietary restrictions that your child needs to prevent an allergy episode.)_____

_____

Field Trip Plan: _____

Please add any additional information you feel is needed to safely care for your child: _____

_____

Authorization for Health Care Provider and School Nurse to Share Information:
I authorize my child's school nurse to assess my child in regards to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/ Guardian Signature _____Date _____

Notes _____

_____

Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Nurse Signature _____Date_____

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