

SOUTH HOLLAND SCHOOL DISTRICT 150

FOOD ALLERGY QUESTIONNAIRE

Dear Parent/Guardian,

Date _____

If your child is allergic to any foods, please indicate the following:

Your child's name _____

Grade _____

Homeroom teacher _____

1. What food(s) is your child allergic to?
2. When and how did you first become aware of the allergy?
3. When was the last time your child had a reaction?
4. Describe the signs and symptoms of the reaction?
5. What medical treatment was provided and by whom?
6. Is your child able to self administer Epi-pen or Benadryl? If so, where will he/she keep medication?
7. If no medication will be provided for child at school, please explain why?

If medication is required while your child is in school, please contact the nurse's office to obtain the "PERMISSION TO GIVE PRESCRIPTION AND NON-PRESCRIPTION MEDICATION" form. The form must be completed by a licensed medical provider and parent/guardian and returned to school.

I understand, in the event my child has an allergic reaction, the parent and possibly 911 will be called.

Parent/Guardian Signature _____ Date _____

Contact phone numbers: _____
