Bernards Township Public Schools

Health Office

Allergy Questionnaire

Student Name_____ Date of Birth_____

What is your child allergic to?

Please specify _____

Did your child ever have a reaction?

____Yes- Give date(s), if possible_____

How was it treated_____

____No

____Blood test, positive

Describe the reaction or symptoms your child exhibits when having an allergic reaction._____

Does your child see an allergist for their allergies?

____Yes-Physician Name_____ Last visit_____-_____-_____

____No

Does your child take any medication for his/her allergy? _____Yes _____No

Name of medication	Dosage	When used (daily, twice daily, as needed)

Is there a need to keep medication at school?

____Yes-please list_____

____No

Please provide any additional information you think would be helpful for the school nurse regarding your child's allergy prevention or emergency treatment.

_____

_____ _____

Parent/Guardian Signature Date