

****Please complete both sides of this form.****

ALLERGY SYMPTOM WORKSHEET

(to be completed by parent)

Student's Name _____ **Grade** _____

Allergy: _____

1. Please **circle the symptoms** that your child has exhibited in the past when medication was needed:

Skin: itching, flushing, hives swelling

Mouth: itching & swelling of lips, tongue, mouth,

Throat: itching, swelling, tightness of throat, difficulty swallowing & speaking, hoarseness, coughs

Chest: cough, chest pain or tightness, shortness of breath, wheezing

Heart: weakness, dizziness, fainting,

Abdomen: nausea, vomiting, diarrhea, pain, cramps

Other symptoms: _____

2. Benadryl ever taken for an allergic reaction? yes no

Date(s) _____

Why? _____

Did your child see a physician at this time? yes no

Physician's Name _____

Physician Findings _____

3. Epinephrine (Epi Pen) ever needed? yes no

Date(s) _____

Why? _____

Did your child see a physician at this time? yes no

Physician's Name _____

Physician's Findings _____

Parent/Guardian Signature _____

Date _____