Allergy Symptom Worksheet

Parents: Please complete this form

Student's Name_____Grade_____

Allergy:_____

1. **Is your child *allergic by touch*? Yes No *by ingestion?* Yes No**

2. **Do you request that your child sit at a peanut free table at lunch? Yes No**

3. Is there a specific way **your child might describe** having an allergic reaction? _____

_____

4. **Does your child wear a Medic Alert tag? Yes No**

5. **Do you wish to provide an extra Epi Pen or Auvi-Q be placed in an unlocked safe in Faculty room next to the cafeteria? Yes No**

6. 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:_____

7. **Benadryl ever taken for an allergic reaction? Yes No**

Date(s)_____

Why?_____

8. **Epinephrine ever taken for an allergic reaction? Yes No**

Date(s)_____

Why?_____

Parent Signature_____**Date**_____