ALLERGY CHECKLIST

1. Name of student _____ Grade _____ Teacher _____

2. Student is allergic to: _____

3. Allergy physician: _____
   Phone : _____

4. Symptoms experienced in the past: (Please check all that apply)
   - ❑ Runny nose
   - ❑ Itchy eyes
   - ❑ Hives
   - ❑ Hoarseness
   - ❑ Wheezing
   - ❑ Dizziness
   - ❑ Nausea
   - ❑ Redness of sting area
   - ❑ Swelling of sting area
   - ❑ Swelling beyond the sting area
   - ❑ Other symptoms (list) _____
   - ❑ Swelling of lips, tongue, throat
   - ❑ Breathing difficulty
   - ❑ Thickened speech
   - ❑ Itching all over body
   - ❑ Skin flushed all over body
   - ❑ Abdominal cramps
   - ❑ Blue color of skin / lips
   - ❑ Extreme weakness
   - ❑ Vomiting

5. Medication(s) taken for allergic reaction:
   Name _____ Dose _____ Times taken _____
   Name _____ Dose _____ Times taken _____
   Name _____ Dose _____ Times taken _____
   - All medications kept at school require medication forms signed by your child's physician and a parent/guardian.
   - Medication must be provided by the parent/guardian. Benadryl is NOT kept in the health room

6. Does your child have an Epi-Pen? Yes_____ No _____

7. Does your child know how to administer his/her medication? Yes _____ No _____

8. For a food allergy, does your child react to contact, ingestion or smelling of the food? Please explain. _____

9. Other information: _____

Signature _____ Date_____