Allergy, Asthma, and Chronic Health Problems Questionnaire

Child’s Name ___________________________________________________________ DOB _______________________

- Medication Allergies: __________________________________________________________
  Describe your child’s reaction to the medication(s): ________________________________

- Dye Allergies, found in medications or foods: ________________________________
  Describe your child’s reaction to the dye(s): ________________________________

**The school nurse does not have access to dye-free medications. Parent/Guardian must supply.**

- Is your child allergic to latex? □ Yes □ No
  Describe your child’s reaction to latex: ________________________________

- Has a doctor stated that your child is allergic to a specific food? □ Yes □ No
  Describe your child’s reaction to the food(s): ________________________________

**If your child has a medical condition that requires a special meal plan, please contact your school cafeteria staff to request the special meals form.**

- Has a doctor stated that your child is allergic to bee, wasp, or insect stings? □ Yes □ No
  List specific insects allergic to: ________________________________
  Describe your child’s reaction to stings: ________________________________

- Does your child have or ever had an epi-pen (This is an injection/shot), that needs to be at school? □ Yes □ No
  Has your child ever had a serious or life threatening allergic reaction to any of the above? □ Yes □ No
  Describe (ambulance called, difficulty breathing, etc.): ________________________________

- Does your child have an asthma action plan? □ Yes □ No
- Does your child currently have an inhaler, that needs to be at school? □ Yes □ No
- Does your child currently have a nebulizer machine, that needs to be at school? □ Yes □ No
- What causes (triggers) your child’s asthma attacks? ________________________________
- When is the last time your child had to use their inhaler/nebulizer? ________________________________
- Has your child ever had a life threatening asthma attack? □ Yes □ No

- Does your child have any other health problems? Explain: ________________________________

**Does your child (per md) require medications for sports, afterschool programs, and/or field trips? SEE NURSE!**