The following information is requested by the school nurse to plan an appropriate program for your child's needs in school, should any emergency situation arise. We would appreciate your

Student Health Questionnaire

Continue on reverse

C. Allergies ☐ No ☐ Yes (If allergies are severe, please provide an allergy action physician.)

*Are the allergies: ☐Mild ☐Severe	**What is your child allergic to? (Check all that apply)**	**Please Specify:**
	☐ Foods:	
Date of Last Severe Reaction: _____/_____/_____	☐ Insect Stings/Bites:	
	☐ Medication:	
Allergy caused by: ☐ Ingestion ☐ inhalation ☐ contact	☐ Plants/Environmental:	
	☐Unknown	

Does your child have a food intolerance? If yes, please specify:_____

Please check all symptoms noted with allergic reaction:

☐ Redness