FREEPORT AREA SCHOOL DISTRICT
Allergy Survey

According to our health records, your child has a serious allergy. In order to provide for the special needs of your child while he/she is at school, it is extremely important that we have the following information. Please answer the questions listed below with as much detail as possible **and return to the school nurse tomorrow.**

Child's name______________________________________ Birth date________________ Grade_________

Telephone number__________________________________ Age allergy was diagnosed_________________

1. Describe your child's allergy symptoms (both mild and severe).

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2. What triggers those symptoms in your child?

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3. Approximately how often does your child have an acute episode?

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4. Does your child understand his/her allergy and how to manage it?

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5. In event your child exhibits serious allergy symptoms during the school day, what procedure would you like the school to follow? (Be very specific.)

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If it becomes necessary for the school to administer medication in an emergency, we will need both the enclosed medication form **(completed and signed by both you and your physician)** and the prescription medication brought in to the school nurse as soon as possible. Thank You.

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(PARENT/GUARDIAN SIGNATURE) (TODAY'S DATE)

PLEASE USE THE REVERSE SIDE TO PROVIDE ADDITIONAL DETAILS