GRACE LEARNING CENTER

Allergy History

Student Name: _____DOB: _____

School: _____Grade: _____Date: _____

Type of Allergy

Check the box next to any allergy your child has experienced, and list name(s) as requested.

☐ Medication student is allergic to: _____

☐ Name of specific food: _____

☐ Environmental allergens: (dust, mites, mold, pets, etc.) _____

☐ Insect bites/stings: _____

Symptoms of Allergy

Check the box next to any symptoms your child has experienced:

☐ Hives

☐ Swelling of: _____

☐ Difficulty in Breathing – Wheezing

☐ Other (describe) _____

☐ Shock

☐ Fainting – Dizziness

☐ Difficulty Swallowing

1. Has your child seen a licensed healthcare provider for any of the allergies indicated above?
   ☐ Yes ☐ No
2. Has your child ever been hospitalized for any allergic event? ☐ Yes ☐ No
   Describe: _____
3. Is medication required immediately after exposure to any allergy producing substance?
   ☐ Yes ☐ No
   If Yes, Name of Medication: _____

If the medication is to be carried by the student, a Self-Carry Consent must be on file. If the medication is to be kept in the health office, a Consent for Medication Administration form must be on file.

4. If no medication is necessary, how should the school treat the allergic event?
   Careful observation ☐ Yes ☐ No
   Call parent/guardian ☐ Yes ☐ No
5. If allergy is to nuts, does your child need to sit at a nut-restricted table? ☐ Yes ☐ No
6. Would you like other families in the classroom to be notified a child in the classroom has a nut allergy?
   ☐ Yes ☐ No

If dietary changes are medically necessary, please contact the Food and Nutrition Department.

Any classroom accommodations needed? _____

Parent/Guardian Name (Print): _____ Phone No. _____

Parent/ Guardian Signature: _____ Date: _____