EST. 1999
PRAIRIE CROSSING
CHARTER SCHOOL
CREATING NATURAL LEADERS

2017 -2018 Allergy History Form

_____ _____/____/_____ _____ _____
Student's name (Last) (First) (Middle initial) Birth date Grade Date

_____ **My child does not have any allergies. (Please proceed to the *Asthma Management Plan* form.)**

Please provide as much detail as possible about your child's present and past allergies. Thorough and accurate information will equip us to create a safe and healthy environment for your child.

1. When and how did you first become aware of the allergy?

2. When was the last time your child had an allergic reaction?

3. Please describe the signs and symptoms of the reaction.

4. What medical treatment was provided and by whom?

5. If medication is required while your child is at school, the enclosed Allergy Emergency Action Plan form must be completed by a licensed medical provider and parent/guardian.

_____ **My child does not need an Allergy Emergency Action Plan.**

6. Please describe the steps you would like us to take if your child is exposed to this allergen while at school.

_____ _____ _____
Parent/guardian name (please print) Parent/guardian signature Date

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