

**Gurnee District 56 Health Services Procedure**

**ANNUAL ALLERGY ASSESSMENT FORM**

Gathering this information will assist in developing a health care plan for your child.

STUDENT NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ PHONE # \_\_\_\_\_

LIST ALL MEDICATION USED: \_\_\_\_\_

**LIFE-THREATENING ALLERGIES:** \_\_\_\_\_

NON-LIFE THREATENING ALLERGIES: \_\_\_\_\_

Has your child had a serious reaction? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when: \_\_\_\_\_ describe: \_\_\_\_\_

Has your child seen the doctor because of the life-threatening allergies? \_\_\_\_\_

Has your child been tested by a physician for this allergy? \_\_\_\_\_

LIST ALL MEDICATION USED: \_\_\_\_\_

How might your child's allergic condition affect school performance or participation in activities? \_\_\_\_\_

Is there a doctor authorization releasing your child from a food allergen-free table? \_\_\_\_\_

Is there a doctor authorization for your child to stay indoors? \_\_\_\_\_

Would you like the students in your child's classroom be aware of your child's allergy? \_\_\_\_\_

Is there anything else we should be aware of? \_\_\_\_\_

\_\_\_\_\_

**During School hours, my child...**

Needs help \_\_\_ Is independent \_\_\_ with making appropriate food choices at lunch/ snacks/class parties.

Needs help \_\_\_ Is independent \_\_\_ with field trips/off campus activities.

Needs help \_\_\_ Is independent \_\_\_ with carrying & administering Epi-Pen safely.

*Your child will need a physician note to be removed from a food allergy table. If an allergic reaction occurs, in which an Epi-Pen needs to be administered, 911 will be called.*

Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_