



Allergy Questionnaire

To be completed by parent

Ankeny Christian Academy
1604 W 1st St
Ankeny, IA 50023

Student Name _____	Date of Birth _____	Grade _____
School ACA _____	School Year _____	Teacher _____
Parent/Guardian _____	Relationship _____	Phone _____
Parent/Guardian _____	Relationship _____	Phone _____
Emergency Contact _____	Relationship _____	Phone _____
Healthcare Provider _____	Phone _____	Fax _____

*This information will provide the school nurse with a better understanding of the child's needs.
This questionnaire needs updated and completed each school year.*

Has this child been diagnosed with allergies/anaphylactic reactions by a healthcare provider? Yes No

Note: Appropriate staff will be notified of student's allergies and emergency plan.

List all allergies, including foods	Child reacts to allergen if: Circle	Describe allergic reaction:	How long does it take to react?
	swallows touches inhales		

Prevention: How does this child prevent and respond to an allergic reaction? (check all that apply)

The child knows what to avoid The child asks about ingredients in food, if unsure
 The child tells other about his/her allergies The child will immediately tell an adult if exposed to an allergen
 The child wears an identifying tag or bracelet alerting others to the allergy
 Other: _____

Allergy Response:
 Has this child ever needed to use an epinephrine auto-injector (EpiPen): Yes No If yes, date of last injection: _____

Are medications needed AT SCHOOL? <input type="checkbox"/> Yes - List <input type="checkbox"/> No	Dose:	Time:
<i>IF medication is needed at school, parent must complete the Medication Authorization Form and bring the medication to school.</i>		

Allergy medication AT HOME: <input type="checkbox"/> Yes - List <input type="checkbox"/> No	Dose:	Time:

Any other information or chronic health problems that would be helpful to know?

Parent/Guardian Signature _____ Date _____

RETURN TO SCHOOL NURSE IMMEDIATELY