VALLEY VIEW PUBLIC SCHOOLS COMMUNITY UNIT DISTRICT 365U

Allergy History Form

STUDENT LAST NAME	STUDENT FIRST NAME
STUDENT ID#	TODAY'S DATE

According to your child's health records, he/she has an allergy to: _____

_____

Please provide us with more information about your child's health needs by responding to the following questions and returning this form to the school office.

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

_____

When was the last time your child had a reaction? _____

_____

Please describe the signs and symptoms of the reaction. _____

_____

What medical treatment was provided and by whom? _____

_____

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

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

_____

_____

PARENT/GUARDIAN NAME	DATE
SIGNATURE	

(Return to Nurse/Designated School Personnel)