Assessment Form: Allergy

Easton Arts Academy
30 North 4th Street, Easton, Pennsylvania 18042
Phone (484) 546-4230 Fax (610) 829-6076

Dear Parent/Guardian of _____

Our records show that your student has allergies. Help us in our efforts to provide appropriate care by completing this form and returning it to the school nurse's office. Thank you.

Sincerely,

School Nurse: _____ Date: _____

Student's Name: _____ Parent/Guardian Phone: _____

Allergy doctor's name: _____ Phone: _____

When is your student most affected by allergies? (circle any applicable)

Fall Winter Spring Summer

What is yout student allergic to? (circle any applicable)

Milk Animal dander Trees/grass/pollens Molds

Bee stings Dust Tree nuts Peanuts

Latex Medicines (specify): _____

Other: _____

Comments: _____

Please check all allergy symptoms that your student experiences:

[ ]	Stuffy, runny, itchy nose	[ ]	Persistent coughing
[ ]	Sneezing	[ ]	Wheezing
[ ]	Rash/Hives	[ ]	Dark circles under eyes
[ ]	Pale appearance	[ ]	Breathing through mouth
[ ]	Tiredness	[ ]	Headaches
[ ]	Irritability	[ ]	Severe, extensive swelling
[ ]	Anaphylactic shock reaction		
[ ]	Other: _____		

Comments: _____

How might yout student's allergic reaction affect school performance or participation in activities? _____

_____

How often does your student see the doctor due to allergies? _____

What medical treatment has been provided for these allerigies? _____

_____

What medications does your student use?

Medication: _____ Dose: _____ How often? _____

Will your student need mediation at school for the allergic reaction? Yes/No

If yes, please contact the school nurse for assistance as soon as possible.

Parent Guardian Signature: _____ Date: _____