EARLY HEAD START/HEAD START
ALLERGY/PARENT QUESTIONNAIRE

Child’s Name _________________________ Teacher _______________ Room _____

Dear Parent/Guardian:

You have indicated on your child’s emergency card or health history that your child has allergies. Please complete this form and return it to school by _________________.

1. Has a doctor diagnosed your child’s allergies?  Yes ____ No ____

2. Which of the following is your child allergic to?  Please list.
   Foods ________________________________________________
   Environmental (trees, pollen, etc.) ___________________________
   Animals _________________________________________________
   Medications ______________________________________________
   Other ____________________________________________________________________________

3. What happens to your child during an allergic reaction? ____________________________________________________________________________

4. Does your child need special care during an allergic reaction?  Yes ____ No ____
   If yes, what care does your child need? ____________________________________________

5. Is your child currently taking medications for allergies?  Yes ____ No ____
   If yes, please list all medications. ______________________________________________________________________________________

6. Does your child need medication at school for treatment of allergies?  Yes ___ No ___

**If your child needs medical attention or medication for an allergic reaction while at school, you and your child’s physician must complete and sign an ALLERGY ACTION PLAN.**

7. Is there anything else we need to know about your child’s allergies? _________________

8. Parent/Guardian Signature _____________________________ Date: ____________

Thank you for your cooperation.

_______________________________  ___________________________  ______________
Head Start/Early Head Start Staff  Phone #                  Date

Reviewed 1-2020