

**Saint Timothy School of Religion  
225 King Philip Drive  
West Hartford CT 06117**

**Allergy Assessment**

Dear parent / guardian of \_\_\_\_\_ :

According to our records your child has allergies. It would be helpful if you would provide us with more information by answering the questions below, and returning this form to me. Thank you.

Sincerely, \_\_\_\_\_  
school nurse date

Student's Name: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ phone: \_\_\_\_\_  
Allergy doctor's name: \_\_\_\_\_ phone: \_\_\_\_\_

When is your child most affected by allergies?  
fall winter spring summer

What is your child allergic to? milk molds bee stings dust  
tree nuts latex animal dander trees/grasses/pollen

medicines (specify): \_\_\_\_\_  
other: \_\_\_\_\_  
comments: \_\_\_\_\_

*please check all allergy symptoms that your child experiences:*

stuffy, runny, itchy nose sneezing persistent cough wheezing  
dark circles under eyes rash/hives pale appearance tiredness  
breathing thru mouth headaches hearing problems irritability  
anaphylactic shock severe, extensive swelling from stings

other: \_\_\_\_\_  
comments: \_\_\_\_\_

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

How often does your child see the doctor because of allergies?  
\_\_\_\_\_

What medical treatment has been provided for these allergies?  
\_\_\_\_\_  
\_\_\_\_\_

What medication(s) does your child use?

name _____	dose _____	how often? _____
name _____	dose _____	how often? _____
name _____	dose _____	how often? _____

Will your child need medication at school for the allergic condition? yes no  
If yes, please contact the school nurse for assistance as soon as possible.

\_\_\_\_\_  
parent / guardian signature

\_\_\_\_\_  
date