community education
AT PARKLAND COLLEGE

STUDENT ALLERGY HISTORY

Please complete this form and return it to the Terry Thies at tthies@parkland.edu.

Child's First Name: Child's Last Name:

Parent/Guardian's First Name: Parent/Guardian's Last Name: Email: Phone:

Please list your child's allergies including, all foods, insects, medications, environmental and latex:

1. **What kind of reaction has your child had to the above listed allergen(s) in the past (note: each reaction can present with different symptoms)?**

   Hives Rash Itching Vomiting Swelling Hard to breathe Wheezing

   Other? ______________________________

2. **When was the last time your child had an allergic reaction?** ______________________________

3. **Did you use an epinephrine auto-injector in this reaction?** Yes No

4. **Have you ever used an epinephrine auto-injector for your child's allergic reaction?** Yes No

   If yes, when? ______________________________

5. **Does your child require an epinephrine auto-injector or any additional medication at camp to keep them safe with allergies?** Yes No

   (If yes, please complete and return the medication authorization form.)

6. **When was your child's last doctor visit for the above listed allergy(ies) and what suggestions did your doctor give if a reaction occurs?**

7. **Did you receive a Emergency Care Plan /Food Allergy Action Plan from your child's doctor?**

   Yes No

Physician/allergist name______________________________ **Phone**____________________

Parent/guardian name______________________________ **Phone**____________________

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PARENT/GUARDIAN SIGNATURE DATE