MONTGOMERY COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
SCHOOL HEALTH SERVICES

Date: _____

Dear Parent/Guardian:

A review of the records on file indicates that _____ has allergies. Management of these conditions varies with each individual. In order for us to assist in the health care of your child, please complete and return the questionnaire below.

1. To what is your child allergic or anaphylactic?_____

   _____

2. What reaction does your child have?

   ☐ Immediate ☐ Delayed

   ☐ Local ☐ Generalized

   Symptoms noted:

   ☐ Swelling of mouth/throat ☐ Hives

   ☐ Tightness in throat ☐ Itching all over/ tingling

   ☐ Difficulty swallowing ☐ Rash

   ☐ Coughing, wheezing ☐ Swelling of face/hands

   ☐ Difficulty breathing ☐ Nausea/vomiting

   ☐ Dizzy/Lightheaded ☐ Diarrhea

   ☐ Fainting ☐ Uneasiness/panic

   ☐ Weak pulse ☐ Other (please explain in #6)

3. Has this condition been diagnosed by a doctor? ☐ Yes ☐ No

4. Has hospital emergency room care ever been required? ☐ Yes ☐ No

5. Will medication need to be given at school? ☐ Yes ☐ No

   If yes, please contact the School Community Health Nurse for the appropriate forms for administration of medication (MCPS 525-13 and/or MCPS 525-14), which must be completed by you and your physician.

6. Additional information to share? _____

_____

Parent/Guardian signature Date

Please contact your School Community Health Nurse for additional questions.

_____

School Community Health Nurse Phone