Meritus Health School Health Program **Washington County Public Schools**

ALLERGIC REACTION CHECK LIST

Student's Name: _____ Date of Birth: ___/___/___ School Year: _____

You have told us that your child had an allergic reaction to _____. Please specify the allergy below and check the reaction(s) your child has experienced.

Does your child use an EPI-PEN? ☐ Yes or ☐ No **Will an Epi-pen be provided to Health Office?** ☐ Yes or ☐ No

For this allergy, have you had an Emergency Room visit? ☐ Yes or ☐ No If yes, please explain: _____

_____

	RASH	ITCHING	PAIN OR SWELLING	TIGHTNESS IN CHEST OR THROAT	WHEEZING	DIFFICULTY BREATHING	FEELING FAINT OR DIZZY	SWELLING OF EYES, LIPS, FACE	SEVERE STOMACH-ACHE	CRAMPS, DIARRHEA	VOMITING
FOODS:											
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MEDICATIONS:											
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
STINGS/ BITES:											
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LATEX	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CHEMICAL	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ENVIRONMENTAL	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Form completed by: _____ **Parent/Guardian Signature:** _____ **Date:** ___/___/___

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