Revised Date:	08/13/2015

NUTRITION COUNCIL ALLERGY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

Name *(Last, First, M.I.):*						☐ M ☐ F	**DOB:** mm/dd
Grade Level:	☐ Kindergarten	☐ First	☐ Second	☐ Third	☐ Fourth	☐ Fifth	
Teacher:					**School: Arlington Elementary**		

STUDENT ALLERGY HISTORY

Is the student Asthmatic? ☐ Yes ☐ No	**Does the student have a food allergy?** ☐ Yes ☐ No	
Food Allergies: (select all that applies)	☐ Milk	☐ Fish
	☐ Eggs	☐ Shellfish
	☐ Peanuts	☐ Soy
	☐ Tree Nuts	☐ Wheat
	☐ Other	☐ None
If "other" please list:		
Food Allergy Triggers		
☐ Smelling/Inhaling	☐ Eating	☐ Touching
List Symptoms:		
~ Hives (reddish, swollen, itchy areas on the skin) ~ Eczema (a persistent dry, itchy rash) ~ Redness of the skin or around the eyes ~ Itchy mouth or ear canal ~ Nausea or vomiting ~ Diarrhea ~ Stomach pain ~ Nasal congestion or a runny nose ~ Sneezing ~ Slight, dry cough ~ Odd taste in mouth ~ Uterine contractions		
Does the student have any non-food allergies? ☐ Yes ☐ No		
If "yes", please list:		
If medication is needed at the school, have you brought the medication/treatment supplies to school? ☐ Yes ☐ No		
PLEASE NOTE: If medication/treatment supplies will be made available, please be sure to complete the Medication Form for the school.		

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Name of Parent/Guardian (1st Emergency Contact)

____
Parent/Guardian E-mail

____
Parent/Guardian Phone Number

____
Name of Secondary Emergency Contact

____
Secondary Contact Phone Number

____
Signature of Parent/Guardian

This does not replace nor adds to any medical form in the student's medical record in the main office. FOR CLUB USE ONLY.