YOUNG SCHOLARS
OF WESTERN PA
CHARTER SCHOOL

ALLERGY CHECKLIST

1. Name of student_____Grade____Teacher _____

2. Student is allergic to: _____

3. Allergy physician: _____
   Phone : _____

4. Symptoms experienced in the past: (Please check all that apply)
   - □ Runny nose
   - □ Itchy eyes
   - □ Hives
   - □ Hoarseness
   - □ Wheezing
   - □ Dizziness
   - □ Nausea
   - □ Redness of sting area
   - □ Swelling of sting area
   - □ Swelling beyond the sting area
   - □ Other symptoms (list) _____
   - □ Swelling of lips, tongue, throat
   - □ Breathing difficulty
   - □ Thickened speech
   - □ Itching all over body
   - □ Skin flushed all over body
   - □ Abdominal cramps
   - □ Blue color of skin / lips
   - □ Extreme weakness
   - □ Vomiting

5. Medication(s) taken for allergic reaction:
   Name_____Dose_____Times taken _____
   Name_____Dose_____Times taken _____
   Name_____Dose_____Times taken _____
   - ï All medications kept at school require medication forms signed by your child's physician and a parent/guardian.
   - ï Medication must be provided by the parent/guardian. Benadryl is NOT kept in the health room

6. Does your child have an Epi-Pen? Yes____ No _____

7. Does your child know how to administer his/her medication? Yes____No _____

8. For a food allergy, does your child react to contact, ingestion or smelling of the food? Please explain._____

9. Other information: _____

SIGNATURE _____DATE_____