THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA and
FLORIDA DEPARTMENT OF HEALTH IN SARASOTA COUNTY
SCHOOL HEALTH SERVICES
1960 LANDINGS BOULEVARD, SARASOTA, FL 34231 PHONE (941) 927-9000

ALLERGY HISTORY

Instructions: Parent/Guardian should complete this form and return it to the School Health Room.

Student Name _____ DOB _____

School _____ Grade _____ Date _____

TYPE OF ALLERGY

Check the box next to any allergy your child has experienced and list name/s as requested.

☐ **Medication student is allergic to**

_____

☐ **Name of specific food**

_____

☐ **Environmental allergens dust, mites, mold, pets, etc.**

_____

☐ **Insect bites/stings**

_____

SYMPTOMS OF ALLERGY

Check the box next to any symptoms your child has experienced.

☐ Hives or giant hives
☐ Swelling of _____
☐ Difficulty in breathing - wheezing
☐ Difficulty swallowing
☐ Shock
☐ Fainting - dizziness
☐ Other (describe) _____
_____

1. Has your child seen a doctor for any of the allergies indicated above? ☐ Yes ☐ No
2. Has your child ever been hospitalized for any allergic event? ☐ Yes ☐ No
   Describe _____
3. Is medication required immediately after exposure to any allergy producing substance? ☐ Yes ☐ No
   If Yes, **name of medication** _____

   (Note: We must have both the medication and the signed Medication/Treatment Authorization Form on file in order to administer the medication.)
4. If no medication is necessary, how should the school treat the allergic event?
   Careful observation ☐ Yes ☐ No
   Call parent/guardian ☐ Yes ☐ No

If dietary changes are medically necessary, a doctor's order with diagnosis is required.

Comments _____

Parent/Guardian Name (Print) _____ Phone No. _____

Parent/Guardian Signature _____ Date _____