

**Golf School District 67**  
**Student Allergy Information**

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Student Name: \_\_\_\_\_

Please list your child's allergies:

\_\_\_\_\_  
\_\_\_\_\_

Please provide us with more information about your child's health needs by responding to the following questions and return this form to the school office.

1. When and how did you first become aware of the allergy?

\_\_\_\_\_  
\_\_\_\_\_

2. When was the last time your child had a reaction?

\_\_\_\_\_  
\_\_\_\_\_

3. Please describe the signs and symptoms of the reaction.

\_\_\_\_\_  
\_\_\_\_\_

4. What medication treatment was provided and by whom?

\_\_\_\_\_  
\_\_\_\_\_

5. If medication is required while your child is at school, the enclosed Emergency Action Plan (EAP) form must be completed by a licensed medical provider and parent/guardian.

\_\_\_\_\_  
\_\_\_\_\_

6. Please describe the steps you would like us to take if your child is exposed to this allergen while at school.

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Signature:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent or Guardian Signature:

\_\_\_\_\_  
Date