

**Seekonk Public Schools
Health Services Department**

Student Name _____

Parent Questionnaire

In an effort to get to know your child better, I would like to request the following information relevant to your child's medical consideration.

1. How did you discover your child had an allergy to

2. How old was your child when s/he experienced their first reaction? _____
3. What symptoms did s/he experience? _____

4. What treatment was necessary? _____

5. Has your child had any further allergic reactions since the first episode?
___ **NO** ___ **YES**. If yes, what happened the next time? _____

6. Does your child see a specialist/allergist? ___ **NO** ___ **YES**. If yes, please list
name and telephone number: _____

7. With your child's allergy, does s/he react when s/he:
Ingests _____ **Touches** _____ **Inhales** _____
8. Do you feel it is necessary for your child to sit at the "allergy free" table in the
cafeteria? (N/A at SHS) ___ **NO** ___ **YES**. If no, please explain:

Our expectation is that you would provide additional safe snacks for your child to be kept in the classroom. If this is not agreeable, please explain:

Parent/Guardian Signature _____

Date _____

Please return this form to the school nurse as soon as possible.