



On the medical form, you listed that the student has allergies (i.e. bee/insect stings, shellfish, iodine, nuts, dairy, other foods, pollen, medications, and any other known allergies). When we have the proper information we can accommodate many allergies. Please complete the questionnaire below. Responding as promptly and thoroughly as possible will help us!

Student Name:_	Date of Birth:	
Allergen #	_ of	
Alternative/relate When diagnosed How diagnosed Sensitivity (ingest Symptoms during	ed/other names: d with this allergy: to this allergen: stion, contact, injection, etc.): ng an allergic reaction (what happens?): n: face swelling and/or difficulty breathing (anaphylactic reaction)? Yes	
Does the studer If yes, pla Has the student If Yes, e. Is the student of If Yes, pla Does the studen	nt take any medication for this allergy? Yes \(\backsquare{\text{No}}\) No \(\backsquare{\text{Dease complete the Medication Addendum}}\) ever been hospitalized for this particular allergy? Yes \(\backsquare{\text{No}}\) No \(\backsquare{\text{Dease complete the Medication Addendum}}\) an allergy desensitization program? Yes \(\backsquare{\text{No}}\) No \(\backsquare{\text{Dease explain in detail on separate sheets as necessary}}\) an an allergy desensitization program? Yes \(\backsquare{\text{No}}\) No \(\backsquare{\text{Dease explain in detail on separate sheets as necessary}}\) at have and carry epinephrine for this allergy? Yes \(\backsquare{\text{No}}\) No \(\backsquare{\text{Dease explain in detail on separate sheets as necessary}}\) at the student must bring two delivery devices to BFS	NO L
Allergen #	_ of	
When diagnosed How diagnosed Sensitivity (ingestingle)	ed/other names:	
Does the studer If yes, pla Has the student If Yes, e. Is the student of If Yes, pla Does the studer	n: face swelling and/or difficulty breathing (anaphylactic reaction)? Yes take any medication for this allergy? Yes \(\backsquare\) No \(\backsquare\) ease complete the Medication Addendum ever been hospitalized for this particular allergy? Yes \(\backsquare\) No \(\backsquare\) explain in detail on separate sheets as necessary an an allergy desensitization program? Yes \(\backsquare\) No \(\backsquare\) ease explain in detail on separate sheets as necessary and have and carry epinephrine for this allergy? Yes \(\backsquare\) No \(\backsquare\) estudent must bring two delivery devices to BFS	No D

Allergen # of	
Allergy/Allergen:Alternative/related/other names:	_
When diagnosed with this allergy:	
How diagnosed to this allergen:	
Sensitivity (ingestion, contact, injection, etc.):	
Symptoms during an allergic reaction (what happens?)	
During a reaction: face swelling and/or difficulty breathing (anaphylactic reaction)? Yes \(\bar{\textsf{L}}\) No Does the student take any medication for this allergy? Yes \(\bar{\textsf{L}}\) No \(\bar{\textsf{L}}\)	. [
If yes, please complete the Medication Addendum	
Has the student ever been hospitalized for this particular allergy? Yes \(\bigcap\) No \(\bigcap\) If Yes, explain in detail on separate sheets as necessary	
Is the student on an allergy desensitization program? Yes ☐ No ☐	
If Yes, please explain in detail on separate sheets as necessary	
Does the student have and carry epinephrine for this allergy? Yes \(\bigcap\) No \(\bigcap\)	
If Yes, the student must bring two delivery devices to BFS	
Additional information:	
Please duplicate and/or attach additional sheets as needed. # sheets attached:	

Parent/guardian: please initial when this addendum is complete:_