



2020-2021 ALLERGY QUESTIONNAIRE

LEXINGTON CHRISTIAN ACADEMY

450 West Reynolds Road, Lexington KY 40503
(859) 422-5700 * www.lexingtonchristian.org

Student's Name: _____ DOB: ___ / ___ / ___

Campus: _____ Grade Level: _____ Homeroom Teacher: _____

Parent/Guardian Name: _____ Cell #: _____

Parent/Guardian Name: _____ Cell #: _____

Emergency Contact (if unable to reach Parent/Guardian): Name: _____

Phone: _____ Relationship: _____

Allergist/Doctor: _____ Phone #: _____

Hospital of Choice: _____

1. Allergen(s): _____

2. Date of student's last allergic episode? ___ / ___ / ___ • Never had an allergic episode

What happened? _____

3. Diagnosed by skin/blood testing? •Yes •No Date ___ / ___ / ___ Physician's Name: _____

4. Has student ever been hospitalized for an allergic episode? Yes• No• Date ___ / ___ / ___

5. Does your child react when they eat the above allergen? •Yes •No

Type of reaction: • Stomachache • Itching • Hives • Itchy throat • Cough/Wheezing
• Anxiety/Restlessness • Swollen lips or tongue • Other _____

6. If this is a food allergy, will you be sending lunch? •Yes •No

7. Does your child react when they touch (or are bitten/stung if Insect) the above allergen?
•Yes •No

Type of reaction: • Rash • Itching • Hives • Itchy throat • Cough/Wheezing
• Anxiety/Restlessness • Swollen lips or tongue • Other _____

8. Does your child react when they smell or inhale the above allergen? •Yes •No

Type of reaction: • Stomachache • Itching • Hives • Itchy throat • Cough/Wheezing
• Anxiety/Restlessness • Swollen lips or tongue • Other _____

9. Can your child sit near someone eating the allergen? •Yes •No

10. Does your child know what the allergen looks like and how to avoid it? ·Yes ·No

11. What do you do at home (accommodations, diet restrictions, substitutions)? _____

12. Can your child eat things processed in a facility that also processes the allergen? ·Yes ·No

13. Can the school send a letter home notifying the classroom about your child's allergy in order to decrease the chances the allergen will be brought to school by a classmate? ·Yes ·No

14. List the Medication(s) your student takes for allergic reactions

Name of Medication	Dosage	Time of Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Additional comments: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____