SAINT IGNATIUS COLLEGE PREP
ALLERGY ASSESSMENT

Student Name: _____Date of Birth:_____
Last Name, First Name :

Parent Name:_____

Home Phone: _____Work Phone: _____Cell Phone: _____
area code + number area code + number

According to your student's health records, she/he has a problem with allergies. It would be helpful if you would provide us with more information by completing this form, and returning it to the school nurse.

Sincerely,
Margie Balogh BSN, RN PEL-CSN
Phone:312-432-8331

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☐ **Allergies are no longer a problem for my student. Sign below and return this form to the School Nurse.**

When is your student most affected by allergies? (Check all that apply)

☐ **Seasonal** - ☐ Fall ☐ Winter ☐ Spring ☐ Summer

☐ **Exposure**- ☐ Eaten ☐ Touched ☐ Inhaled

What specific things is he/she allergic to? (Check all that apply)

☐ Milk ☐ Bee Stings ☐ Peanuts/Tree Nuts, please list types:_____

☐ Drugs ☐ Dust ☐ Grasses/Trees, please list types: _____

☐ Mold ☐ Pollen ☐ Animal dander

☐ Food, please list types:_____ ☐Other: _____

Comments:_____
_____

The common symptoms of allergy that your child experiences are: (check all that apply)

☐ Tired ☐ Sneezing ☐ Persistent cough ☐ Wheezing breath sounds

☐ Pale ☐ Rash/Hives ☐ Dark circles / bags under eyes ☐ Breathing through mouth

☐ Irritability ☐ Hearing problems ☐ Swelling of exposure site ☐ Breathing problems

☐ Anaphylactic Shock reaction ☐ Headaches ☐ Stuffy, runny, itchy nose ☐ Diagnosis of ASTHMA

☐ Other: _____ ☐ Itchy, watering eyes

Last allergic reaction was: _____ Was Emergency Care required? ☐ YES NO ☐

How does your child's allergic condition affect his/her school performance, participation and attendance :

_____

Does your child know what his/her allergy is and what to avoid? ☐ YES ☐NO
How often does he/she see the physician because of allergies?

_____
What medication does he/she use?

Name : _____
Dose :_____
Frequency :_____

Name _____
Dose _____
Frequency_____

Will it be necessary for this student to have medication available here at school for the allergic condition?
☐ No ☐ Yes. If yes, please complete a medication form and/or self-administration form.

Signature: _____
Date: :_____
Month Day Year

- **Please return completed forms to the school nurse prior to the beginning of classes.**
- **Forms can be mailed to:**

Dean's Office/ATTN: Nurse
Saint Ignatius College Prep
1076 W. Roosevelt Road
Chicago, IL 60608-1594