SAINT LOUIS
COVENANT SCHOOL

ALLERGY QUESTIONNAIRE – 2024-2025 SCHOOL YEAR

(One form must be completed for each child.)

Mother's Full Name_____

Mother's Email Address_____

Mother's Contact Phone Number_____

Father's Full Name_____

Father's Email Address_____

Father's Contact Phone Number_____

Name of Child_____

Grade_____

Does the above-named child have any allergies? **YES** or **NO**

If **YES**, please list the allergies that the above-named child has as follows. If an item is not applicable, place N/A on item line.

Foods:_____

Insects:_____

Medications:_____

Latex: _____

Other:_____

If allergic to peanuts or nuts, will a reaction occur if such products touch the skin? **YES** or **NO**

If **YES**, please provide any additional details:_____

_____

Does the above-named child use an **EpiPen** prescribed by a Physician? **YES** or **NO**

If the above-named child is in grades 4th-8th, will he or she self-administer and keep EpiPen in his/her possession (such as in backpack, pocket, purse or satchel) while in School? **YES** or **NO**

Will parent provide an EpiPen to use at School? **YES** or **NO**

If **YES**, how many EpiPens will be provided to the School? _____

Does the above-named child use an **Inhaler** prescribed by a Physician? **YES** or **NO**

If the above-named child is in grades 4th-8th, will he or she self-administer and keep Inhaler in his/her possession (such as in backpack, pocket, purse or satchel) while in School? **YES** or **NO**

Does the above-named child need **allergy-related prescription medication** administered at school? **YES** or **NO**

Does the above-named child need **allergy-related over-the-counter medication** (such as antihistamines) administered at school? **YES** or **NO**

Does the above-named child need **other prescription medication** administered at School? **YES** or **NO**

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If **YES** was answered to any of the above questions, please acknowledge the following, as parent of the above-named child, by checking the boxes in front of each item below:

__As the parent of the child listed above, I must provide **Physician Instructions and/or an Action Plan signed by a Physician** ***directly and in-person*** to the School Office if the above-named child must have a Physician-prescribed medication at School such as an EpiPen, Inhaler or other prescription medicine.

__As the parent of the child listed above, I must provide such prescription and/or over-the-counter medication ***directly and in-person*** to the School Office, and, at which time, I will be asked to complete and sign a "**Permission to Administer Medication Form**" while present at the School Office. This form will be kept in a Ziploc bag along with the medication provided.

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As the parent of the child listed above, I understand that should an allergic reaction occur, Saint Louis Covenant School will first attempt to contact the Parents before calling 911.

By completing and submitting this form, I acknowledge that the information contained herewith is accurate to the best of my knowledge. I also acknowledge that my electronic completion and submittal of this Allergy Form shall be considered the equivalent of my written signature.

Full name of Parent completing this form: _____

Relationship to Child: _____

Signature of Parent completing this form: _____

Date: _____