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.