SonShine
PRESCHOOL

Allergy Questionnaire

Child's Name:_____

Parent Name:_____

1. Does your child have any allergies or sensitivities to food? Yes ___ No___

   - If YES, was the allergy or sensitivity diagnosed by a doctor? Yes ___No ___
   - If YES, does your child have an Epi-Pen? Yes ___ No___
   - Medication used to treat the allergy: _____
   - Food your child is allergic or sensitive to:_____

2. Does your child have allergies to something other than food? (Bee sting, dust, mold, seasonal…)

   Yes _____ No_____

   - What is your child allergic to?_____
   - What symptoms present?_____
   - Medication used to treat the allergy:_____