

PHYSICIAN'S REPORT ON CHILD WITH ALLERGIES

(Last Name) (First) (Middle) (BD) (ID#)

Home Address Zip Code

Father's Name Mother's Name Telephone

School Grade Non-Attending

Dear Doctor,
The School Nurse of Chicago Public Schools is requesting your cooperation in completing the following questions. Please return this form to the above child's school and retain a duplicate copy for your files.

School Nurse
Student has an allergy to what specific things? Milk Drugs Animal Dander Latex Trees/grasses Molds
 Dust Bee stings Pollens Peanuts
 Other _____

Skin Test Completed? Yes No Date _____
When is the child most affected by the allergies? Fall Winter Spring Summer

Student's symptoms (circle all that apply):

- | | | | | |
|-----------------|-----------------|----------------------|--|---------------|
| Mouth - | itching | swelling of the lips | tongue | mouth |
| Throat - | itching | hoarseness | sense of tightness in the throat | hacking cough |
| Skin- | itchy rash | hives | itch and swelling of the face or extremities | |
| Gut- | nausea | abdominal cramps | vomiting | diarrhea |
| Lungs- | wheezing | shortness of breath | repetitive coughing | |
| Heart- | "thready" pulse | | "passing out" | |
| Nose- | stuffy | runny | itchy | sneezing |
| Eyes- | dark circles | bags | watery | |
| Neuro- | headaches | irritability | anaphylactic shock reaction | |

Special Needs: (Check if modifications required) Other (please describe) _____

___P.E / Exercise Modifications ___Gym ___Classroom ___Lunch ___Animals in Class

Medical Treatment prescribed _____

How often is the student seen by the physician? _____ Next scheduled appointment _____

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		

Physician's Name _____ **Hospital Affiliation** _____
(Please print or type)

Address _____ **Telephone #** _____ **Fax #** _____

Physician's Signature _____ **Date** _____