Allergy Survey

STUDENT NAME _____ YEAR LEVEL____
Surname First name

Please indicate any allergies your daughter may have, including food allergies.

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Outline usual signs and symptoms for each allergy.

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Describe the treatment and or medication required in the event of an allergic reaction.

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Please also complete the "Student Own Medication Form" and provide the Health Centre with any required current medication.

Does the student carry her own Emergency Medication? ☐ YES ☐ NO

_____ _____

Parent/Guardian Name **Parent/Guardian Signature**

Date: _____