BROKEN ARROW PUBLIC SCHOOLS
Health Services

Allergy/Intolerance Questionnaire for Physicians

Student Name ____________________ Date of Birth ______________ Date ___________

Physician Name ____________________ Physician Office Number ______________

1. Does this student have a definitive diagnosis of an allergy? ☐ Yes ☐ No

2. What is the offending allergen? ☐ Peanut ☐ Milk/Dairy Products
   ☐ Latex ☐ Insect (specify) ____________________
   ☐ Other (specify) ____________________

3. Is the allergy ingested, contact or inhaled? ____________________

4. What is the student's immediate response to the allergen? ____________________
   ____

5. Does this student have a food intolerance? ☐ Yes ☐ No

6. What is the offending food? ☐ Milk/Dairy Products
   ☐ Other (specify) ____________________
   ☐ Other (specify) ____________________

7. Have you instructed the student to carry an EpiPen at all times? ☐ Yes ☐ No

8. Are there any other medications you have advised the student to have on hand in the event of an allergic reaction or intolerance? ☐ Yes ☐ No

   If yes, please indicate the names, doses and frequencies of the medications.

Name of Medication	Dosage	Frequency

9. Please indicate any specific precautions or accommodations which should be taken or made to minimize the risk of exposure to the offending food and/or allergic reaction:
   ____
   ____
   ____

Physician Signature ____________________ Date ______________ reviewed 9/15