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 □ Insect (specify) □ Milk/Dairy Products
   □ Latex □ 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.

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<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Frequency</th>
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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