Lockport Township High School District 205
ALLERGY ASSESSMENT

Dear Parent or Guardian of: _____ Date: _____

According to your child's health records, he/she has an allergy to: _____

_____

Please provide us with more information about your child's health needs by responding to the following questions and returning this form to the school office.

1. When and how did you first become aware of the allergy?

2. When was the last time your child had a reaction?

3. Please describe the signs and symptoms of the reaction.

4. What medical treatment was provided and by whom?

5. Name and phone number of the physician treating the allergy.

Child's Physician:

Name (Print): _____
Address: _____
Telephone: _____
Signature: _____ Date: _____