SonShine
PRESCHOOL

2024 Allergy Questionnaire

Child's Name: _____

Parent's Name: _____

1. Does your child have any allergies or sensitivities to food? Yes _____ No _____
    - If YES, was the allergy or sensitivity diagnosed by a doctor? Yes _____ No _____
    - If YES, does your child have an Epi-Pen? Yes _____ No_____
    - Medication used to treat allergy: _____
    - To what foods is your child allergic or sensitive?

      _____
2. Does your child have allergies to something other than food? (insect bites or stings, dust, mold, seasonal, etc.) Yes _____ No _____
    - Please list allergies: _____
    - Please list allergy symptoms: _____
    - Medication(s) used to treat allergy: _____

⇒ **Please note:** If your child's allergy has been diagnosed by a physician, we must have an ***Allergy Action Plan*** on file. The SonShine Office Staff will provide you with an ***AAP*** form if needed.