

PHYSICIAN'S REPORT ON CHILD WITH ALLERGIES

(Last Name)	(First)	(Middle)	(BD)	(ID#)
Home Address		Zip Code		
Father's Name		Mother's Name		Telephone
School		Grade		Non-Attending

Dear Doctor,

The School Nurse of Chicago Public Schools is requesting your cooperation in completing the following questions. Please return this form to the above child's school and retain a duplicate copy for your files.

School Nurse

Student has an allergy to what specific things?

- ☐ Milk

☐ Drugs

☐ Animal Dander

☐ Latex

☐ Trees/grasses

☐ Molds

☐ Dust

☐ Bee stings

☐ Pollens

☐ Peanuts

☐ Other _____

Skin Test Completed? Yes ☐ No ☐ Date _____

When is the child most affected by the allergies? ☐ Fall ☐ Winter ☐ Spring ☐ Summer

Student's symptoms (circle all that apply):

Mouth -	itching	swelling of the lips	tongue	mouth
Throat -	itching	hoarseness	sense of tightness in the throat	hacking cough
Skin-	itchy rash	hives	itch and swelling of the face or extremities	
Gut-	nausea	abdominal cramps	vomiting	diarrhea
Lungs-	wheezing	shortness of breath	repetitive coughing	
Heart-	"thready" pulse		"passing out"	
Nose-	stuffy	runny	itchy	sneezing
Eyes-	dark circles	bags	watery	
Neuro-	headaches	irritability	anaphylactic shock reaction	

Special Needs: (Check if modifications required) Other (please describe) _____

___P.E / Exercise Modifications ___Gym ___Classroom ___Lunch ___Animals in Class

Medical Treatment prescribed _____

How often is the student seen by the physician? _____ Next scheduled appointment _____

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		

Physician's Name _____ **Hospital Affiliation** _____
(Please print or type)

Address _____ **Telephone #** _____ **Fax #** _____

Physician's Signature _____ **Date** _____