Allergy/Intolerance Questionnaire for Physicians

Student Name _____ Date of Birth _____

Physician Name _____ Physician Phone # _____

1. Does this student have a definitive diagnosis of an allergy? ☐ Yes ☐ No
2. What is the offending allergen? _____
3. What is the student's immediate response to the allergen?

   _____

   _____

4. Does this student have a food intolerance? ☐ Yes ☐ No
5. What is the offending food? _____
6. Have you instructed the student to carry epinephrine at all times? ☐ Yes ☐ No
7. 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

Physician's Signature: _____ Date:_____