Student Seasonal Allergy Survey **(Note: This survey is only for <u>seasonal</u> allergies.)**

Child's Name: _____ Grade: _____ Date: _____

During which months are seasonal allergy symptoms experienced?

_____ Jan/Feb/Mar _____ Apr/May/Jun

_____ Jul/Aug/Sept _____ Oct/Nov/Dec

_____ Year Round

Check all the allergy symptoms experienced:

_____ runny or stuffy nose ____ itchy/watery eyes _____ sneezing

_____ scratchy or sore throat _____ itchy nose _____ itchy ears

_____dark rings under eyes _____ headache _____ loss of productivity

Does your child experience hives or itchy skin? _____ Yes _____ No

Rate the severity of your child's allergy symptoms on a scale of 1-10 (1= mild; 10 = severe): _____

Has your child used a seasonal allergy medicine in the last 12 months? If yes, which one(s)?

Prescription: _____

OTC (Over-the-Counter) or holistic/herbal: _____

Which of the following have you done in the last 12 months for your child's allergies?

_____ visited a doctor specifically for seasonal allergy symptoms

_____ visited a doctor for another reason and asked about seasonal allergy treatment

_____ have not seen a doctor for allergy issues

Other than your child, do any other members of your household suffer from seasonal allergies?

_____ parent _____ sibling 12 and over _____ sibling under 12 _____ no one else

<u>Do you want your child to stay indoors for recess or gym during the days or weeks when allergy symptoms are greatest</u>? _____ Yes _____ No

Parent/Guardian signature: _____

Please complete survey and return to the school nurse.