H. Serv. (Revised 11/04)

CPS CHICAGO PUBLIC SCHOOLS

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 ___Other

Medical Treatment prescribed_____

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

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** _____