# SUMMER LEADERSHIP AND CHARACTER DEVELOPMENT ACADEMY

## INSECT ALLERGY QUESTIONNAIRE

NAME: ________________________________________

**Please complete all of the questions below regarding history of food allergies and return this form with your application. If more space is needed, please use another sheet and identify each issue by question number.**

1.) Please list the insect species you are allergic to: ____________________________________________________

a.) Age at the time of diagnosis or first occurrence : ____ Age at the time of the most recent occurrence:___

b.) Were you treated for this in a hospital or emergency room? (circle) **YES NO**

c.) Were you prescribed an Epi-Pen to carry with you? (circle) **YES NO**

d.) Did you have any of the following symptoms when you were last stung or bitten: (cirlce)

| | | |
|---|---|---|
| Pain at the site of the bite or sting | **YES** | **NO** |
| Swelling or redness at the site of the bite or sting | **YES** | **NO** |
| Hives (urticaria) | **YES** | **NO** |
| Swelling away from the site of the bite or sting | **YES** | **NO** |
| Shortness of breath or difficulty breathing | **YES** | **NO** |
| Throat swelling or tightening | **YES** | **NO** |
| Stomach pain | **YES** | **NO** |
| Loss of consciousness | **YES** | **NO** |
| Other symptoms? | **YES** | **NO** |

If "YES" to other symptoms, please describe: ________________________________

2.) Have you received allergy shots (immunotherapy) for your insect allergy? (circle) **YES NO**

If "YES", dates your allergy treatments started and ended ______________________

3.) Certification: By signing below, I hereby certify that the above information is true and accurate to the best of my knowledge.

__________________________________________ Applicant's Signature

______________________ Date