

Pre-Employment Allergy Screening Form

Personal Information

Full Name

Date of Birth

Email

Phone

Allergy Information

Do you have a history of allergies?

Type(s) of Allergy (check all that apply)

☐

Pollen

☐

Dust

☐

Food

☐

Drug

☐

Insect Stings

☐

Latex

☐

Other

If other, please specify

Describe any reactions experienced

Are you currently taking any allergy medications?

If yes, please specify

Emergency Information

Emergency Contact Name

Emergency Contact Phone

Signature

Date