Allergic Reaction Parent Questionnaire

Student Name_____ Date of Birth_____ Grade_____

Allergy(s) _____

Health Care Provider Phone Number

_____ _____

1.Has the student been diagnosed with allergies/anaphylactic reaction by a health care provide yes _____ No_____

2. Age at Diagnosis_____ 3. Does the student have asthma yes_____ no _____

Please check what usually triggers you child's allergy attack/episode

Peanuts_____ Seafood_____ Latex_____ Fish_____ Tree Nuts_____

Eggs_____ Soy_____ Milk/dairy_____ Perfumed/Scented products_____

Insect Stings/Bites_____ List_____

Animals_____ List_____

Medications_____ List_____

4. How soon after contact does the student react _____Minutes _____Hours _____Days

5. When was the last time your child was treated for an allergic reaction _____

6. In the past how many times has your child been treated in the emergency room_____

8. Has your child ever received Epinephrine for an allergic reaction Yes_____ No_____

9. Does your child have early warning signs (physical or emotional) that indicate your child is starting to have an allergic Reaction If so please list_____

10. Does your child recognize these signs/symptoms yes _____ No_____

11. If your child has an Epipen prescribed

Has he/ she received training on how to self-administer yes_____ No_____

Has he/she ever self-administered Yes _____ When _____ No_____

Please circle the students usual signs / symptoms of an allergic reaction/ anaphylaxis

MOUTH	Itching Swelling of Lips ,tongue, or mouth
THROAT	Itching sense of tightness in throat Horseness Hacking Cough
SKIN	Hives Itching Rash swelling of face or extremities Flushing
STOMACH	Nausea Abdominal Cramps Vomiting Diarrhea
LUNG	Shortness of Breath Repetitive Cough Wheezing
HEART	"Thready Pulse" " Passing out"
OTHER Please write in box to Right	

Please list the medications your child takes to treat allergies

Medication	How Much	When is it Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please remember, all medications to be given at school must follow schools medication policy. A prescribing health care professional may authorize self-administration if the student is deemed capable by both Health Care Professional and School Nurse . A medication order form must be filled out by your provider and parent signature is needed. The medication must be in its original Labeled container, not expired, and properly labeled

All school health information is handled in a respectful and confidential manner. May the school health office share this information with school staff on a "need to know basis" yes_____ No_____

Parent Guardian Signature_____ Date_____

School Nurse Reviewed _____ Date_____