**Camp Hill School District**

**Student Food Allergy/Intolerance Parent Questionnaire**

Student name \_\_\_\_ \_Date\_\_\_ \_

**Allergy History**

Does your child have a food □ allergy or □ intolerance diagnosis from a healthcare provider?

Age of child at diagnosis:

Does your child have a history of asthma?□ No □ Yes

What is your child’s allergy?

□ Peanuts □ Tree nuts (walnuts, pecans, etc.) □ Eggs □ Milk □ Wheat □ Soy □ Fish □ Shellfish

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If egg or milk be specific if they can have these items in baked form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Was the reaction when your child □ ate/drank □ touched □ breathed the allergen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When was your child’s last reaction?

What are the signs and symptoms of the allergic reaction? (can include things your child might say.)

Allergen: Symptoms:

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**Common Symptoms**

**Skin**: hives, itching, rash, flushing, swelling (face, arms, hands, legs)

**Mouth**: itching, swelling (lips, tongue, mouth)

**Abdominal:** nausea, cramps, vomiting, diarrhea

**Throat:** itching, tightness, difficulty swallowing, hoarseness, cough **Lungs:** shortness of breath, repetitive cough, wheezing, chest tightness **Heart:** chest pain**,** loss of consciousness

How were past reactions treated?

Was there an emergency room visit? □ No □ Yes Explain Did your healthcare provider give a prescription for medication? □ No □Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have that medication? □ No □ Yes

**School Accommodations**

My child needs to sit at a **nut free** table for lunch. □ No □ Yes

My child needs their classroom to be peanut/tree nut free. □ No □ Yes

I will supply safe snacks for my child. □No □Yes

My child may eat snacks that “may have been processed in the same facility” as his allergen. □No □Yes

**Self Care**

Is your child able to monitor and prevent his/her own exposures by:

Knowing what foods to avoid? □ No □ Yes

Asking about food ingredients? □ No □ Yes

Reading and understanding food labels? □ No □ Yes

Telling an adult immediately after an exposure? □ No □ Yes

Wearing a medical alert bracelet, necklace, watch band? □ No □ Yes

Telling peers and adults about their allergy? □ No □ Yes

Can your child administer their own emergency medication? □ No □ Yes

Please add anything else you would like the school to know about your child’s health:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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plan signed by their physician and a parent/guardian. Action plans are available by request of your school

nurse or can be downloaded from the nurse’s website.

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Parent/guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_

**This information will be reviewed yearly by the school nurse (RN).**

Reviewed by RN Date\_\_\_\_\_\_\_\_

Reviewed by RN Date\_\_\_\_\_\_\_\_

Reviewed by RN Date\_\_\_\_\_\_\_\_

Reviewed by RN Date\_\_\_\_\_\_\_\_