Northshore
School District

School:
Address:

Phone:

ALLERGY QUESTIONNAIRE

Student Name: Birth date: Grade:

School health records indicate your child has an allergy. In order to better understand your child's situation and to have the most current health information about your child please complete and return this form to the School Nurse:
Students with Life threatening conditions must have medications, treatment and nursing care plan in place before attending school.

What is your child allergic to?
Please specify:

Signs of Emergency: Please check each symptom your child has had when s/he is exposed to the allergen:

- ☐ Tightness of throat and/or chest
- ☐ Difficulty breathing or talking
- ☐ Generalized itching, rash or hives
- ☐ Swelling of eyes, lips, tongue throat or neck
- ☐ Other:
- ☐ Vomiting, stomach cramps or diarrhea
- ☐ Seizures
- ☐ Loss of consciousness
- ☐ Blue or grey discoloration of lips or fingernails

Does your child take medication for this allergy?
☐Daily ☐As needed ☐No medication is needed

☐ Epinephrine (Epi-Pen) and/or other:
Please specify:

When was the allergy diagnosed?

When was the most recent episode of an allergic reaction? Please specify the date, symptoms and treatment:

Has your child ever been hospitalized, gone to the emergency room, or visited the doctor due to an allergic reaction? ☐Yes ☐No
If yes, please explain:

If your child has a severe allergy, the nurse will create, with you and the school staff a plan of care for your child including emergency management of the problem while in school. We also work on prevention strategies unique to your child to avoid an emergency situation.

Parent/Guardian Signature Date