SEVERE ALLERGY ASSESSMENT

Dear Parent/Guardian,

Please complete this form if your child is allergic to a food substance or stinging insect. We need your answers to the following questions in order to provide effective first aid if your child is exposed to that food substance or insect. By returning this questionnaire promptly, school personnel will be able to provide specific first aid measures for your child. **If your child requires medication of any kind, please have your physician complete the "*Release for Dispensing Medication*" form.**

****Please return this form by the first day of school.**

STUDENT'S NAME _____ **GRADE** ____

What food substance is your child allergic to? _____
Has your child ever had a severe reaction to the above? ___ Yes ___ No

Has your child ever had a severe reaction to an insect sting? ___ Yes ___ No

What symptoms does your child experience? Check ALL that apply:

___ Swelling of face or extremities
___ Swelling of lips, tongue or mouth
___ Tightness of the throat
___ Hoarseness/cough/difficulty breathing
___ Abdominal cramps/vomiting
___ Rapid pulse

AT SITE OF INSECT STING:
___ Redness
___ Swelling
___ Itchiness

ARE THESE SYMPTOMS LIFE THREATENING? ___Yes ___ No

How soon after exposure do symptoms occur? _____
Has the allergy been diagnosed by a doctor? ___ Yes ___ No

What treatment has been recommended?
___ Oral medication (Name of med: _____)
___ Injection of medication (Name of med: _____)
**** A medication form, signed by your doctor, and medication (Epi Pen, Benadryl, etc.) must be turned in to the office by the first day of school.**

Does the allergy limit the child's participation in any of the following school activities?
___Field Trips ___ Lunch ___Gym ___Outdoor sports Other_____

FOR CHILDREN WITH LIFE THREATENING REACTIONS, PLEASE INDICATE SPECIFIC EMERGENCY INSTRUCTIONS: _____
_____

Parent's Signature_____ **Date**_____