Allergy and Anaphylaxis Questionnaire for Parents

Date _____

Child's Name_____ Grade_____ DOB _____

Parent's Name_____

Name of Doctor treating Allergy _____

Name of Clinic_____ Clinic Phone_____

Hospital preference (in case of emergency) _____

History and Assessment Data

What triggers the student's allergies or anaphylaxis? (check all that apply)

□ Food/Beverages (list)	□ Insect Stings (list)	□ Medications
□ Allergens (pollens, dust, dust mites, mold, animal dander)	□ Dietary Substances (food additives/preservatives)	□ Irritants (Smoke, perfumes, cleaning products)
□ Animals (list)	□ Unknown	□ Other (list)

What are the student's signs and symptoms of an allergic reaction?
(check all that apply)

□ Tightness of throat and/or chest	□ Wheezing or difficulty breathing	□ Generalized tingling or itching	□ Generalized rash or hives
□ Acute coughing/sneezing	□ Nausea, vomiting or diarrhea	□ Apprehension or anxiety	□ Swelling of eyes, lips, tongue, throat or neck
□ Facial flushing	□ Fall in blood pressure	□ Dizziness or fainting	□ Seizures
□ Rapid, thread, weak or unattainable pulse	□ Loss of consciousness	□ Cyanosis (bluish or grayish color of skin or lips)	□ Other (list)

Medications used by this student:

1.	2.
3.	4.

Please complete other side →

Anaphylaxis Questions

Has a health care provider diagnosed your child with an anaphylactic reaction? **(If so, your child should have an EpiPen available at school with the physician's signed authorization)**	☐ Yes ☐ No
How old was your child when they were diagnosed with anaphylaxis?	
How soon after contact does your child react?	
In the past, how often has your child been treated for a minor reaction?	
How often has your child been treated for a major reaction in the emergency room?	
Are there any **early** warning signs that indicate an allergic reaction? (please list)	☐ Yes ☐ No
Does your child recognize these early warning signs?	☐ Yes ☐ No
Does your child have any other health conditions (such as asthma)? (Please list)	
Please list the circumstances surrounding the diagnosis of your child's severe allergic reaction:	

Please identify what your child does to prevent or avoid an allergic reaction:

	Yes	No
My child knows what to avoid.		
My child tells other people about his/her allergies.		
My child will tell an adult immediately if exposed to an allergen (i.e.stung by a bee, etc)		
My child wears a medical alert bracelet or necklace.		
Other		

What modifications does this student need to prevent exposure to allergen(s) at school? (Describe)

Signature of Parent/Guardian Date
