# ST. MARY'S COUNTY PUBLIC SCHOOLS

*Department of Student Services/ St. Mary's County Health Department*

## ALLERGY INFORMATION

Student's Name: ________________________________________ Date of Birth: ______________________________

Allergic to: ________________________________________________________________________________

Diagnosed by Doctor: ☐ Yes ☐ No Doctor's Name: ____________________________

Date of Last Allergic Reaction: ____________________________

1. Do you consider the allergy to be life threatening to your child? ☐ Yes ☐ No
   **If Yes, an emergency action plan may be needed at school.**

2. Please list the medications your child takes for this allergy (everyday and as needed)

| | Name of Medication | Dose | Frequency |
|---|---|---|---|
| **(In School)** | | | |
| | | | |

**If medication is needed at school, please have your doctor complete a Medication Authorization form.**

| | | | |
|---|---|---|---|
| **(At Home)** | | | |
| | | | |

3. Does your child have a prescribed EpiPen for emergency use? ☐ Yes ☐ No

4. Please check only those symptoms which you have observed when your child has had an allergic reaction:
   - ☐ itching or swelling of lips, tongue, or mouth
   - ☐ nasal congestion
   - ☐ runny nose, sneezing, or sniffling
   - ☐ itching or sense of tightness in the throat
   - ☐ sore throat or throat clearing, "hacking" cough
   - ☐ hoarseness
   - ☐ nausea or vomiting
   - ☐ abdominal cramps or diarrhea
   - ☐ hives
   - ☐ swelling about the face or extremities
   - ☐ difficulty breathing, shortness of breath or wheezing
   - ☐ difficulty swallowing or choking
   - ☐ repetitive coughing
   - ☐ dizziness or fainting
   - ☐ shock (fall in blood pressure and increased thready pulse rate)
   - ☐ unconsciousness
   - ☐ other ______________________________

5. Progression of symptoms were: (Please check.)
   - ☐ increasing and worsening rapidly
   - ☐ early, mild symptoms with apparent resolution followed by rapid development of lung and/or heart symptoms
   - ☐ other ________________________________________

6. How long after being exposed to the allergen did your child develop symptoms? (Please check.)
   - ☐ immediately
   - ☐ within 15 – 20 minutes
   - ☐ within an hour
   - ☐ longer than one hour (specify time) ______________________

7. Has your child ever been hospitalized (emergency room) for an allergic reaction?
   ☐ Yes ☐ No

8. Does your child know to avoid the allergen? ☐ Yes ☐ No

9. If your child has a nut allergy, do they need to sit at the nut-free table during lunch? ☐ Yes ☐ No

Parent(s)'/Legal Guardian(s)' Signature ____________________ Date ______________________