



Carroll County Public Schools Allergies/Anaphylaxis-Parent Health Questionnaire

Student Name: _____ Date: _____
 Date of Birth: _____ Grade: _____

You have indicated on the Emergency Procedure Card and/or health forms that your child has an allergy or history of an anaphylactic reaction. Please complete the following questionnaire and return to your school nurse as soon as possible.

1. Please list what student is allergic to: _____
2. Please list any additional **suspected** or **mild** allergies: _____
3. Does your child also have asthma? Yes _____ No _____
4. Please circle only the symptoms that your child has experienced during an allergic reaction:

Mouth:	Itching	Tingling	Swelling	
Throat:	Tightness	Hoarseness	Hacking Cough	
Lungs:	Shortness of breath	Repetitive Cough	Wheezing	
Skin:	Hives	Itchy Rash	Swelling	
Stomach:	Nausea	Stomachache	Abdominal Cramps	Vomiting/Diarrhea
Heart:	Thready Pulse	Fainting	Skin appears blue	Pale
General:	Panic	Chills	Sudden Fatigue	Fear of Impending Doom

6. How long after the exposure did symptoms begin? (minutes/hours) _____
 Date of last reaction: _____
 If no reaction, when was your child diagnosed by allergy testing? _____
7. Has your child ever received an Epinephrine-Auto-Injector? Yes / No
 If so, when? _____
8. Was your child hospitalized? Yes / No If so, when? _____
9. Does your child know how to avoid exposure to the allergen(s)? Yes / No
 Additional info: _____
10. If your child has a peanut or nut allergy, do you expect your child to sit at the peanut/nut free table provided? Yes / No

***I understand and agree that by declining to have my child sit at a peanut/nut free table, no additional precautions will be taken in the cafeteria for other tables/areas to restrict peanut/nut products, and my child will be solely responsible for his/her management of exposure to the allergens.**

11. Has an Epinephrine Auto-Injector and/or Antihistamine been prescribed for your child?
Yes / No

If yes, a CCPS Medication Form and/or Allergic Reaction Plan with Medication Order must be completed by the health care provider and parent.

*** NOTE: School emergency epinephrine will be kept at school and will not be available for field trips or at extracurricular activities. The availability of emergency medication does not relieve the parent's responsibility to provide their child's personal medication to treat known allergies.**

CCPS protocols require use of epinephrine administration as the first line of defense for serious allergic reactions. If a student experiences a potentially serious allergic reaction, epinephrine in the prescribed dosage will be administered first, unless specifically ordered differently by the physician.

Please review the following:

- I understand that any medication will not necessarily be given by a school nurse. The medication may be given by trained school staff. I release school staff from any liability in the administration of this medication at school.
- Medical/Medication information may be shared with school staff working with your child and emergency responders.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition.
- An assessment must be completed by the health care provider, parent, and school nurse before a student can self-carry and/or administer an Epinephrine Auto-Injector or any medication.

Health Care Provider Name: _____ Phone Number: _____

Parent/Guardian Name (Print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Please note: Medication will only be given following CCPS Medication Procedures. The information you supply will be handled in a confidential manner to be used by the school nurse to guide care if an emergency arises. If clarification is required beyond this form, the nurse will contact the parent/guardian and/or the child's health care provider. If you have questions, please call the school nurse.

Received by School Nurse

Nurse Signature: _____ Review Date: _____