Forest Lake Area Schools
Health Services - Nursing

Severe Allergy Student Questionnaire
School Year: ____________

Student Name: ____ Birthdate: ______________________
School Attending: _______________________________________ Grade: ________________________

Parent/Legal Guardian:______________________________ Relationship to Student: ________________
Home Phone: __________________ Work: ____________________ Cell: ________________________
Parent/Legal Guardian:______________________________ Relationship to Student: _______________
Home Phone: __________________ Work: ____________________ Cell: ________________________

Primary Physician: ______________________ Clinic: _________________ Phone: ________________
Allergist: ______________________________ Clinic: _________________ Phone: ________________

1. Has your child been diagnosed with an allergy by a healthcare provider? ☐ Yes ☐ No
2. Indicate what your child has an allergy to (circle all that apply):

Peanuts	Soy	Vapors
Eggs	Insect Stings	Tree Nuts (walnuts, pecans, etc.)
Milk	Fish/Shellfish	Other: ___________________________
Latex	Chemicals	___________________________

3. How old was your child when the allergy was first discovered? ______________________________
4. How frequently has your child had an allergic reaction? _____________________________________
5. How have past allergic reactions been treated?____
6. Does your child take any medication prescribed by your physician for their allergy? If so, please indicate medication name and frequency of use. ____
7. Does your child have an emergency medication for their allergy? If so, does your child know how to use their emergency medication? ____
8. Has your child ever been treated in the emergency room or hospitalized for severe allergic reaction/anaphylaxis? If so, please explain (when, how long of stay, treatment, etc): ______________
____
____
9. How quickly do symptoms typically occur after exposure to allergen?__________________________

Complete Back Side

10. What are the signs and symptoms that your child experiences when having an allergic reaction? (circle all that apply).

    Skin: Hives Itching Rash Flushing Pale Swelling (face, arms, hands, legs)

    Mouth: Itching Blue in Color Swelling (lips, tongue, mouth)

    Abdominal: Nausea Cramps Vomiting Diarrhea

    Throat: Itching Tightness Hoarseness Cough Trouble breathing or swallowing

    Nose: Itching Sneezing Runny Nose

    Lungs: Shortness of Breath Repetitive Cough Wheezing

    Heart: Weak Pulse Dizziness Confusion Faint Loss of Consciousness

11. Is your child aware of their allergy and able to make decisions to avoid allergen? ________________

    ____

12. Do you feel it is necessary for your child to sit at a special table at lunch due to their allergy?

    ____

13. Do you feel your child should sit in the front of the school bus due to their allergy? ______________
14. Is there anything else you would like the school to know about your child's health/allergies?

    ____

Parent/Legal Guardian Signature: ___________________________________ Date: ________________

Please note:

- If your child has a severe/life-threatening allergy, we request that you make accommodations with the health office regarding your child's emergency medications & signed authorizations/forms
- Please fill out and submit an *Authorization for Administration of Medication at School* form and provider/prescriber's anaphylaxis orders/action plan to the appropriate health office
- If the parent/legal guardian and provider/prescriber feel the student can self-carry and self-administer their emergency medication, please also fill out and submit a *Self-Carry/Self-Administration Medication Authorization Form* to the appropriate health office.
- If the student has a food allergy that requires a complete food substitution, we require that your physician fill out a *Special Diet Statement Request Form* and return to the appropriate health office.