North Santiam School District

# SEVERE ALLERGY SUPPLEMENTAL FORM

School Year: _____

Student name: _____ Date of birth: _____

Grade: _____ School: _____

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|---|---|
| What is your child severely allergic to? | What **symptoms has your child experienced?**<br>☐ Facial swelling ☐ Throat swelling ☐ Hives or rash<br>☐ Difficulty breathing or swallowing ☐ Hoarseness<br>☐ Burning sensation ☐ Changes in skin color<br>☐ Sneezing/wheezing/coughing ☐ Abdominal pain<br>☐ Nausea/ vomiting/ diarrhea ☐ Other (describe below:)<br>_____ |
| When was your child's first severe allergic reaction? | |
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| How does your child's reaction occur?<br>☐ Contact ☐ Inhalation ☐ Ingestion ☐ Sting | Has your child needed emergency treatment or had to be hospitalized because of a severe allergic reaction?<br>☐ No ☐ Yes ☐ If yes when? |
| Does your child have emergency medications prescribed to treat their severe allergy? ☐ No ☐ Yes | |
| If yes, which device does your child currently have:<br>☐ Amneal (0.15 mg) ☐ Amneal (0.3 mg)<br>☐ Auvi-Q (0.15 mg) ☐ Auvi-Q (0.3 mg)<br>☐ EpiPen Jr (0.15 mg) ☐ EpiPen (0.3 mg)<br>☐ Teva (0.15 mg) ☐ Teva (0.3 mg) | How has the reaction been treated in the past?<br>(Medication name(s), dose and frequency) |
| Who is currently treating your child's allergies?<br>(Name and phone number) | Does your child also have *asthma*? ☐ Yes ☐ No<br>If yes, what is used to control your child's asthma? |
| <u>List of medications taken on a daily or routine basis (include name, dose and frequency):</u> | |
| Is there anything else that is important to know about your child's health? | |

Parent signature: _____ Date: _____