

Severe Allergy Parent Questionnaire

Please take a few minutes to complete this questionnaire regarding your child's food allergy so that we can provide the best care for your child in school.

Child's Name _____ Birth Date _____ Home Phone _____

Mother's Name: _____ Cell # _____ Work # _____

Father's Name: _____ Cell # _____ Work # _____

Emergency Contact: _____ Cell # _____ Home # _____

Physician Name: _____ Phone _____

Has your child been diagnosed with allergies/anaphylactic reaction by a doctor? Yes No

- What is the known food allergy or other allergy? _____
- At what age was the child diagnosed? _____
- What symptoms does your child exhibit? (Circle all that apply)
 - **Skin:** Most anaphylactic reactions involve the skin.
 - Hives, welts, or wheals (raised bumps): Hives can cause severe itching
 - Generalized erythema (redness)
 - Swelling in the face, eyelids, lips, tongue, throat, hands, and feet
 - **Breathing:** Swelling of the surrounding tissues narrows the airways.
 - Difficulty breathing, wheezing, chest tightness
 - Coughing, hoarseness
 - Nasal congestion, sneezing
 - **Cardiovascular:** Blood pressure may drop to dangerously low levels.
 - Rapid or irregular heart beat
 - Dizziness, faintness
 - Loss of consciousness, collapse
 - **General**
 - Tingling or sensation of warmth - Often the first symptom
 - Difficulty swallowing
 - Nausea, vomiting
 - Diarrhea, abdominal cramping, bloating
 - Anxiety, fear, feeling that you are going to die, confusion

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- Does your child react to skin contact with the allergen? Yes No
 - If yes, what is the reaction? _____
- Does your child react to swallowing (ingestion) the allergen? Yes No
 - If yes, what is the reaction? _____
- How soon after exposure does your child react? _____
- What allergy testing has been performed to document this allergy? _____
- In the past, how often has your child been treated for minor reaction? _____
- In the past, how often has your child been treated for a major reaction and /or been treated in the emergency room? _____
- Has an EpiPen had to be used? _____. When was it last used? _____
- Does your child know how to avoid the allergen (causes of allergic reaction)? Yes No
- Please check what your child does to prevent or avoid an allergic reaction:
 - Knows what to avoid- _____
 - Tell others about his/her allergies
 - Tell an adult immediately if exposed to an allergen (i.e. stung by bee, ate a peanut etc...)
 - Wear a medical alert bracelet or necklace
 - Avoid contact with animals in classroom
 - Ask about ingredients in food, if unsure
 - Other: _____
- What other information would you like to share regarding your child's allergy?
- If medication, including EpiPen, is to be given at school, a medication authorization form will need to be filled out yearly. The medication must be in the original labeled container. The RN may also determine that an Emergency Action plan needs to be completed in order to provide safe care of your child while at school.

Please add any additional information that you would like for school personnel to know about your child's allergies.

Parent's Signature: _____ Date: _____