Wausau School District
Student Food Allergy / Intolerance
Parent Questionnaire

Student name _____ Date of birth _____

Parent/guardian _____

Home phone _____ Work _____ Cell _____

Primary health care provider _____ Phone _____

Allergist _____ Phone _____

1. Does your child have a food □ allergy or □ intolerance diagnosis from a healthcare provider? Age of child at diagnosis: _____

2. Does your child have a history of asthma? □ No □ Yes

3. History and Current Status:

What is your child allergic to?

□ Peanuts □ Tree nuts (walnuts, pecans, etc.) □ Eggs □ Milk □ Wheat □ Soy □ Fish □ Shellfish □ Other _____

Was the reaction when your child □ ate/drank □ touched □ breathed the allergen?

When was your child's last reaction? _____

4. Triggers and Symptoms:

What are the signs and symptoms of your child's allergic reaction? (Be specific; include things your child might say.)

_____

_____

How quickly do symptoms appear after exposure to the allergen? _____

What symptoms has your child experienced in the past?

Allergen: _____ Symptoms: _____

Allergen: _____ Symptoms: _____

Allergen: _____ Symptoms: _____

Common Symptoms

Skin: hives, itching, rash, flushing, swelling (face, arms, hands, legs)
Mouth: itching, swelling (lips, tongue, mouth)
Abdominal: nausea, cramps, vomiting, diarrhea
Throat: itching, tightness, difficulty swallowing, hoarseness, cough
Lungs: shortness of breath, repetitive cough, wheezing, chest tightness
Heart: chest pain**,** loss of consciousness

5. Medical Treatment

How have past reactions been treated? _____

Was there an emergency room visit? □ No □ Yes, explain _____

What treatment or medication has your healthcare provider recommended for use in an allergic reaction? _____

Has your healthcare provider given your child a prescription for medication? □ No □ Yes

Do you have that medication? □ No □ Yes

Have you used the epinephrine auto-injector (Epi Pen)? □ No □ Yes

6. School Accommodations

My child needs to sit at a "safe" table for lunch? □ No □ Yes

I will supply a box of safe snacks for my child. □ No □ Yes

My child may eat treats from a package with a label that says "may contain nuts" or "has been processed in the same facility" as his allergen. □ No □ Yes

I would like to be contacted before my child has a treat from a package with a label that says "may contain nuts" or "has been processed in the same facility" as his allergen. □ No □ Yes

7. Self Care

Is your child able to monitor and prevent his/her own exposures? □ No □ Yes

Does your child:

Know what foods to avoid? □ No □ Yes

Ask about food ingredients? □ No □ Yes

Read and understand food labels? □ No □ Yes

Tell an adult immediately after an exposure? □ No □ Yes

Wear a medical alert bracelet, necklace, watch band? □ No □ Yes

Tell peers and adults about the allergy? □ No □ Yes

Firmly refuse a problem food? □ No □ Yes

Does your child know how to use emergency medication? □ No □ Yes

Has your child ever administered their own emergency medication? □ No □ Yes

8. Please add anything else you would like the school to know about your child's health:

_____

_____

Parent/guardian signature _____ Date _____

RN signature _____ Date _____