



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: _____

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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 _____

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