ALLERGY QUESTIONNAIRE FOR PARENT/GUARDIAN

Student's Name _____ School Year _____/_____

School _____ Teacher/ Homeroom _____

Additional paperwork may be needed for food allergies, asthma action plans, asthma medications, etc.

1. Has a doctor diagnosed your child's allergies? ❑ Yes -or- ❑ No
2. Which of the following is your child allergic to? Please list:
   - ❑ **Nuts**: Check one: ❑ Peanuts **or** ❑ Tree Nuts **or** ❑ Both Peanuts **and** Tree Nuts
   - ❑ **Other Foods** **(Special Diet Statement Form May Be Needed)**: _____
     _____
   - ❑ Environmentals (trees, pollen, etc.):_____
   - ❑ Animals: _____
   - ❑ Medications: _____
   - ❑ Other (insect bites/stings, latex, etc.): _____
3. What happens to your child during an allergic reaction? _____
   _____
4. Does your child need special care during an allergic reaction? ❑ Yes -or- ❑ No
   If Yes, what special care does your child need? _____
5. Is there anything else we need to know about your child's allergies? _____
6. Does your child have Eczema? ❑ Yes -or- ❑ No
7. Does your child have a history of Asthma? ❑ Yes (higher risk of severe allergic reaction) ❑ No
   If Yes, please complete a separate **FPS ASTHMA PACKET** for asthma medications needed at school
8. Does your child have a history of Anaphylactic Reaction? ❑ Yes -or- ❑ No
   If Yes, was an Epinephrine injection given? ❑ Yes -or- ❑ No
   If Yes, please describe reaction_____
9. Is your child currently taking any medications for allergies at home? ❑ Yes -or- ❑ No
   If Yes, please list all medications: _____
10. Does your child need medication at school for treatment of an allergic reaction? ❑ Yes -or- ❑ No

If your student needs medical attention or medication for an Allergic Reaction while at school, your student's medical provider must complete and sign an ALLERGY ACTION PLAN. Keep in mind that the medications kept at school must have a pharmacy label and the details must match the student and the details on the Action Plan.

Parent/Guardian Signature _____ Date _____

ALLERGY ACTION PLAN

Attach child's photo

Student'sName_____

School Year _____/_____ Teacher/ Homeroom _____

School _____

Student is allergic to: _____

Child also has Asthma ❑ Yes -or- ❑ No Child has had anaphylaxis ❑ Yes -or- ❑ No

IMPORTANT: Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.

FOR SEVERE ALLERGY AND ANAPHYLAXIS

What to look for: →→→	**What to do!**
If Student has ANY of these severe symptoms after exposure (eating, sting, etc.), **GIVE EPINEPHRINE!** • Shortness of breath, wheezing or coughing • Skin color is pale or has a bluish color • Weak pulse • Fainting or dizziness • Tight or hoarse throat • Trouble breathing or swallowing • Swelling of lips or tongue that bother breathing • Vomiting or diarrhea (if severe or combined with other symptoms) • Many hives or redness over body • Feeling of "doom," confusion, altered consciousness, or agitation	1. Give epinephrine right away! Note time when epinephrine was given. **2. Call 911.** a. Ask for ambulance with epinephrine b. Tell rescue squad when epinephrine was given 3. Stay with student and: a. Call parent/guardian and student's doctor b. Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes c. Keep the student lying on back. If the student vomits or has trouble breathing, keep student lying on his or her side 4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine a. Antihistamine b. Inhaler/bronchodilator

❑ **SPECIAL SITUATION** (check box if applicable)

If this box is checked, student has an extremely severe allergy to an insect sting or the following food(s): _____.

Even if the student has MILD symptoms after a sting or eating these foods, **GIVE EPINEPHRINE!**

FOR MILD ALLERGIC REACTION

What to look for: →→→	**What to do!**
If a student has had any mild symptoms, **monitor the student.** Symptoms may include: •Itchy nose, sneezing, itchy mouth •A few hives •Mild stomach nausea or discomfort	Stay with student and: •Watch the student closely. •Give antihistamine (if prescribed). •Call parent/guardian and student's doctor •If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Student's Name _____ School Year _____/_____

EMERGENCY CONTACTS		
NAME	**PHONE NUMBER**	**RELATIONSHIP**

MEDICATIONS

***If more than one epinephrine is selected, then either one can be used*

NAME / ROUTE	**TYPE / BRAND** (if applicable)	**DOSE**
ANTIHISTAMINE, by mouth		
EPINEPHRINE, Intramuscular		❑ 0.15 mg (Junior) ❑ 0.3 mg (Regular)
EPINEPHRINE, Intranasal		❑ 1 mg (4 years and older who weigh 33 to 66 lbs (15 to 30 kg) ❑ 2 mg (for adults and children who weigh 66 pounds)
OTHER:		

OPTION TO SELF CARRY / SELF ADMINISTER

***Check and/or initial any below that apply to this student*

- If student is to self-carry his/her epinephrine, help may still be needed to administer medication
- If student is to self-carry epinephrine, school will need to be supplied with a backup auto-injector
- Two doses are to be made available at school by parent/guardian:
- A second dose of epinephrine can be given 5 minutes or more, after the first dose if symptoms persist, recur, or worsen.

I am in agreement and authorize the medication/plan as stated in this two page plan (see page 1). I certify that this student requires such medication be given during school hours and that no alternative schedule is medically advisable.

Medical Provider Signature_____**Date**_____

Print Provider Name_____Phone_____

Address_____City/State_____Zip Code_____

Parent/Guardian Signature_____**Date**_____

NOTE: This form also serves as the FPS Authorization for Medication Plan for Allergies.