SHELDON INDEPENDENT SCHOOL DISTRICT
Allergy—Parent /Guardian Questionnaire

STUDENT NAME_____ **Date of Birth:** _____

School _____ **School Year**_____ **Teacher**_____ **Grade** _____

Please complete this form and return to your school nurse as soon as possible so that we may give appropriate instruction to school personnel concerning your child's allergy.

Has your child been diagnosed with allergic/anaphylactic reaction by a health care provider? ☐ Yes ☐ No

Child's age at time of diagnosis _____

Does your child have Asthma? ☐ Yes ☐ No If yes, will you keep a rescue inhaler at school? ☐ Yes ☐ No

Other medical conditions: _____

Please list all items your child is allergic to. ***Please be specific.***_____

_____

Reaction can occur by (*check all that apply*): ☐ Ingestion ☐ Contact ☐ Inhalation ☐ Other_____

PLEASE CHECK ALL ALLERGY SYMPTOMS THAT YOUR CHILD MAY HAVE IF EXPOSED TO ALLERGEN:

☐ Difficulty Breathing ☐ Wheezing ☐ Chest Pain Or Tightness ☐ Flushed Or Pale Color ☐ Rapid Pulse

☐ Loss Of Consciousness ☐Dizziness ☐ Fainting ☐ Nausea ☐ Vomiting ☐ Fear ☐Anxiety

☐ Hives ☐ Itchy Rash ☐ Trouble Swallowing ☐Itchy Throat ☐ Tight Throat ☐ Cough

☐ SWELLING: How much and where? _____

☐ Other Symptoms: _____

How soon after contact does your child react? _____Minutes _____Hours _____Days

What are the early-warning signs (physical and/or emotional) that indicate your child is starting to have an allergic reaction?

_____

Does your child recognize the early warning signs? ☐ Yes ☐ No

Does your child know how to avoid allergens (causes of allergic reactions)? ☐ Yes ☐ No

Please check what your child does to prevent or avoid an allergic reaction

_____ Knows what to avoid (list:_____)

_____ Tells other people about his/her allergies

_____ Tells an adult **immediately** if exposed to an allergen

_____ Wears a medical alert bracelet or necklace

_____ Ask about ingredients in foods, if unsure about contents

_____ Firmly refuses food/items that might cause an allergic reaction

_____ Other:_____

Is your child fully aware of his/her allergy, methods of avoidance and proper treatment? ☐ Yes ☐ No

Please list all medications prescribed by your physician to treat your child's allergies:

Medication	Dose	Time Given
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child been taught to self administer the medication? ☐ Yes ☐ No If yes, when was the last time? _____

Has your child ever been treated in the ER or admitted to the hospital for a severe allergic reaction? ☐ Yes ☐ No

If yes please explain *(when/symptoms/number of visits)* _____

_____

Does your child's physician recommend special accommodations when eating? ☐ Yes ☐ No

Specify: _____

Please have the prescribing physician fill out the allergy action plan and return it to the school nurse.

EMERGENCY CARE AT SCHOOL FOR ALLERGIC REACTION

- RECOGNIZE SYPMPTOMS OF ALLERGIC REACTION. DO NOT LEAVE STUDENT ALONE.
  Symptoms usually begin within minutes of exposure, but may be delayed. Sometimes symptoms improve, only to recur or progress a few hours later.
- IMMEDIATELY ACCOMPANY TO HEALTH OFFICE OR CONTACT SCHOOL NURSE
- TREAT WITH EPI-PEN AND BENADRYL if ORDERED (EPI-PEN INSTRUCTIONS ON BACK)
- **CALL 911, THEN CONTACT THE PARENT/GUARDIAN AT THE NUMBERS LISTED ABOVE**
- ENCOURAGE THE STUDENT TO STAY CALM. PROVIDE COMFORT AND SUPPORT.
- HAVE STUDENT BREATHE SLOWLY AND DEEPLY IN THROUGH THE NOSE AND OUT THROUGH THE MOUTH.
- STAY WITH STUDENT UNTIL EMS ARRIVES. MONITOR FOR INADEQUATE BREATHING AND BEGIN RESCUE BREATHING IF NECESSARY

An epinephrine pen may be given by trained staff

If a medication is to be given at school, a medication authorization form must be completed yearly. The medication must be in the original container and labeled with the student's name.

Please inform your child to tell an adult immediately if exposed to an allergen.

In an emergency the student will be transported by ambulance to the hospital. Any charges incurred are the responsibility of the parent/guardian.

Please add anything else you would like school personnel to know about your child's allergies.

_____

_____

Parents/Guardians Contact Information

Name _____ Phone # _____ Phone # _____

Name _____ Phone # _____ Phone # _____

Physician's Name _____ Phone _____

I authorize the release information of my child_____ between the nurse and the physician.
Student's Name

I give permission for the above information to be shared with the appropriate staff of the school.

_____	_____	_____
Please Print Parent/Guardian Name	Parent /Guardian Signature	Date