FORSYTH COUNTY SCHOOLS

# Allergy Parent Questionnaire

(To be completed by a parent or guardian)

Student's Name: _____ Date of Birth: _____ FCS Student Number: _____

## ALLERGY INFORMATION

1. What is your child allergic to? (*food, insects, medication, latex or other*) _____
2. When was your child diagnosed with this allergy? _____
3. Please list any other medical conditions, diagnoses, development concerns, or health issues that may affect your child's allergy or care at school:
   _____
   _____
4. Does your child have asthma or a history of wheezing? ☐ YES ☐NO
5. When did your child's last experience an allergic reaction? _____
6. What symptoms does your child typically experience during an allergic reaction? (Check all that apply)

| | | |
|---|---|---|
| ☐ Itchy, runny nose, sneezing | ☐ Nausea | ☐ Shortness of breath |
| ☐ Itchy mouth | ☐ Vomiting once | ☐ Difficulty swallowing |
| ☐ A few hives, localized rash | ☐ Repeated vomiting/diarrhea | ☐ Dizziness/fainting |
| ☐ Swelling of lips or tongue | ☐ Widespread rash/hives | ☐ Pale or bluish skin |
| ☐ Throat tightness | ☐ Repetitive cough/wheezing | ☐ Other: |

7. Is your child aware of their allergy and able to recognize or report symptoms of an allergic reaction? ☐YES ☐NO
8. Has your child ever experienced an allergic reaction requiring emergency medical treatment (911/EMS, emergency department visit, or hospitalization)? ☐YES ☐NO
   If YES, please describe: _____
9. Has your child ever experienced anaphylaxis (a severe allergic reaction)? ☐YES ☐NO
   If YES, please describe: _____
10. Has your child ever been treated with epinephrine for an allergic reaction? ☐YES ☐NO
    If YES, please explain: _____
11. When was the last time your child received epinephrine? (if applicable) _____
12. How did your child respond after epinephrine was administered? (if applicable) _____
13. Have there been any recent changes in your child's allergy, reactions, or treatment? ☐YES ☐NO
    If YES, please describe: _____

## ALLERGY MEDICATION AND TREATMENT INFORMATION

14. Please list all prescription and over the counter (OTC) allergy medications your child currently takes, including daily and as-needed medications administered at home.

| Medication Name | Dosage | Time and Frequency Administered | Possible Side Effects/Concerns |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

_____ _____ _____

Parent Name (PRINT) Parent Signature Date