FARMINGTON SCHOOLS

Allergy Questionnaire

Date Completed:_____

Student_____ DOB_____ School year: _____

Please complete and return to the School Nurse. The following information will be used to develop an emergency plan and additional interventions for your child's safety and the information may be shared with staff that work with your child.

Person to Contact:	Relationship:	Work Phone:	Home Phone:
1 ._____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Health Care Provider:	Clinic:	Phone:
_____	_____	_____

Hospital:	Phone:
_____	_____

Has your child been diagnosed with allergies/anaphylactic reactions by a health care provider? __Yes __No

Child's age at diagnosis of allergies/anaphylaxis _____

Please check what usually triggers (starts) your child's allergy attack/episode.

- ☐ animals: _____
- ☐ eggs
- ☐ fish
- ☐ latex
- ☐ medications: _____
- ☐ milk/dairy products
- ☐ other: _____
- ☐ peanuts
- ☐ perfumed/scented products
- ☐ shellfish
- ☐ soy
- ☐ tree nuts
- ☐ wheat

How soon after contact does your child react? ____Minutes ____Hours ____Days

In the past, how often has your child been treated for a minor reaction? _____

In the past, how often has your child been treated for a major reaction &/or been treated in the emergency room? _____

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

Does he/she recognize these signs? ____ Yes ____ No

SYMPTOMS OF ALLERGIC REACTION

All symptoms can become life-threatening. Severity of symptoms can quickly change.

Mouth	**Itching/swelling of lips, tongue, or mouth**
Throat *	**Itching, sense of tightness in throat, hoarseness, hacking cough**
Skin	**Hives, itchy rash, swelling of face or extremities**
Gut	**Nausea, abdominal cramps, vomiting, diarrhea**
Lung *	**Shortness of breath, repetitive coughing, wheezing**
Heart *	**"Thready" pulse, "passing out"**

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

__ Know what to avoid (list_____)
__ Tell other people about his/her allergies
__ Tell an adult **immediately** if exposed to an allergen (i.e. stung by bee, ate a peanut, etc.)
__ Wear a medical alert bracelet or necklace
__ Avoid wearing brightly colored clothing or perfumed products which may attract insects
__ Avoid contact with animals in classroom
__ Ask about ingredients in foods, if unsure about contents
__ Firmly refuse food that might be a problem food
__ Other_____

Please list all medications prescribed by a health care provider to treat your child's allergies:

MEDICATIONS TAKEN EVERY DAY				
Medication Name	**Dose**	**Times per Day**	**Home**	**School**
MEDICATIONS TAKEN AS NEEDED FOR ALLERGIC REACTION				
Medication Name	**Dose**	**Times per Day**	**Home**	**School**

How well does your child take his/her allergy medications?

- Can take medication by self
- Forgets to take medication
- Needs help taking medication
- Not using medication now

In an emergency the student will be transported by paramedics to the hospital. Transportation in a non-emergency situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

An Epipen may be given by trained staff.

If medication is to be given at school, a medication authorization form must be completed yearly. A prescribing health professional may authorize self-administration of medication if the student is deemed capable. The medication must be in the original labeled container.

Please inform your child to **tell an adult immediately** if exposed to an allergen (i.e. stung by a bee, ate a peanut, etc.)

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

Information was provided by_____ _____ _____
Name Relationship Date

I authorize reciprocal release of information related to allergies between the health office staff and the health care provider.

_____ _____
Parent/Guardian Signature Date