SEVERE ALLERGY QUESTIONNAIRE

Dear Parent/Guardian: Please fill out the following questionnaire and return to the school nurse as soon as possible. The information will be used to help in the care of your child. The information will be shared by staff who will be caring for your child.

Name of Child: _____ Date of Birth: _____

1. What does your child have a severe allergy to?

2. When and what happened that caused your child to be diagnosed with this allergy?

3. Does your child have asthma? ☐ yes ☐ no
   If so, does your child have an inhaler? ☐ yes ☐ no

4. Does your child react by:
   Ingesting (eating) ☐ yes ☐ no If so: ☐ mild reaction ☐ severe reaction
   Absorption (touch) ☐ yes ☐ no If so: ☐ mild reaction ☐ severe reaction
   Inhalation (breathing allergen in when in the same room) ☐ yes ☐ no
   If so: ☐ mild reaction ☐ severe reaction
   Injection (sting/bites) ☐ yes ☐ no If so: ☐ mild reaction ☐ severe reaction

5. What symptoms does your child experience when having an allergic reaction? (Circle all that apply.)
   Skin and Mouth: (Most reactions mild or severe involve the skin.)
   Hives, welts, or wheals (raised bumps): Hives can cause severe itching.
   Generalized erythema (redness)
   Swelling in the face, eyelids, lips, tongue, throat, hands, feet
   Respiratory: (Narrowing of the airways.)
   Difficulty swallowing, throat tightness
   Chest tightness, difficultly breathing
   Coughing, hoarseness
   Nasal congestion, sneezing
   Cardiovascular: (Blood pressure may drop.)
   Rapid or irregular heart beat
   Dizziness, fainting
   Loss of consciousness, collapse
   General:
   Tingling or sensation of warmth (Often the 1st symptom)
   Nausea, vomiting
   Diarrhea, abdominal cramping, bloating
   Anxiety, fear, confusion

6. How quickly do symptoms typically occur after exposure to allergen?

7. What are the first symptoms your child typically experiences?

8. What have you done in the past to successfully prevent a reaction from becoming severe?

8. How often has your child been treated for a minor reaction?

9. How often has your child been treated for a major/severe reaction (home or hospital)?

Was epinephrine (Epi-Pen/ Auvi-Q) used for treatment? ☐ yes ☐ no
If so, when was the last time epinephrine was used?
If you administered the epinephrine, when and with what symptoms did you decide to give the epinephrine?

10. When was the last time your child had an allergic reaction?
Was it mild or severe?

11. Is your child aware of their allergy? ☐ yes ☐ no

12. Is your child aware of signs and symptoms of an allergic reaction? ☐ yes ☐ no

13. Does your child know to alert an adult if they are having an allergic reaction? ☐ yes ☐ no

14. Does your child know what foods to avoid to prevent an allergic reaction? ☐ yes ☐ no

15. Does your child need to eat at a different table from the other children in the classroom? ☐ yes ☐ no
Please keep in mind your child may feel left out if they are not allowed to sit with the other children. We do not allow children to share their food though it is impossible to see every child's every move.

16. Is there anything else you would like the nurse or staff caring for your child to know?

17. Would you like to talk or meet with the school nurse? ☐ yes ☐ no
If so, please list the best way to reach you to call or set up a meeting.

Printed Name of Parent: _____

Signature: _____ Date _____