FBISD Severe Allergy Parent Questionnaire

Please take a few minutes to complete this questionnaire regarding your child's food allergy so that we can provide the best care for your child in school.

Child's Name_____ Birth Date_____ Home Phone_____

Mother's Name: _____ Cell #_____ Work #_____

Father's Name: _____ Cell #_____ Work #_____

Emergency Contact: _____ Cell #_____ Home #_____

Physician Name: _____ Phone_____

Has your child been diagnosed with allergies/anaphylactic reaction by a doctor? ☐ Yes ☐ No

- What is the known food allergy or other allergy? _____
- At what age was the child diagnosed? _____
- What symptoms does your child exhibit? (check all that apply)

Skin: Most anaphylactic reactions involve the skin.
____Welts or wheals (raised bumps): Hives can cause severe itching
____Generalized erythema (redness)
____Swelling in the face, eyelids, lips, tongue, throat, hands, and feet

Breathing: Swelling of the surrounding tissues narrows the airways.
____Difficulty breathing, wheezing, chest tightness
____Coughing, hoarseness
____Nasal congestion, sneezing

Cardiovascular: Blood pressure may drop to dangerously low levels.
____Rapid or irregular heart beat
____Dizziness, faintness
____Loss of consciousness, collapse

General
____Tingling or sensation of warmth - Often the first symptom
____Difficulty swallowing
____Nausea, vomiting
____Diarrhea, abdominal cramping, bloating
____Anxiety, fear, feeling that you are going to die, confusion

FBISD Health Services

Anaphylaxis Action Plan needed: ____Yes ____No IHP Needed: ____Yes ____No

School RN Signature:_____

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- Does your child react to skin contact with the allergen? □ Yes □ No
  - If yes, what is the reaction? _____
- Does your child react to swallowing (ingestion) the allergen? □ Yes □ No
  - If yes, what is the reaction? _____
- How soon after exposure does your child react? _____
- What allergy testing has been performed to document this allergy? _____
- In the past, how often has your child been treated for minor reaction? _____
- In the past, how often has your child been treated for a major reaction and /or been treated in the emergency room? _____
- Has an EpiPen had to be used? _____ . When was it last used? _____
- Does your child know how to avoid the allergen (causes of allergic reaction)? □ Yes □ No
- Please check what your child does to prevent or avoid an allergic reaction:

____Knows what to avoid _____

____Tell others 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 contact with animals in classroom

____Ask about ingredients in food, if unsure

____Other: _____

- What other information would you like to share regarding your child's allergy?

- If medication, including EpiPen, is to be given at school, a medication authorization form will need to be filled out yearly. The medication must be in the original labeled container. The RN may also determine that an Emergency Action plan needs to be completed in order to provide safe care of your child while at school.

Please add any additional information that you would like for school personnel to know about your child's allergies.

_____

_____

_____

Parent's Signature: _____ Date: _____