Severe Allergies and Anaphylaxis
Intake Form/Parent Questionnaire

Student Name:	DOB:	Grade:	School Year:

Does your child have a physician-diagnosed severe allergy? ☐ Yes ☐ No

Name and phone # of physician treating child's allergy: _____

Child is allergic to (check all that apply):

☐ Peanuts ☐ Tree Nuts ☐ Eggs ☐ Milk ☐ Fish ☐ Shellfish ☐ Soy ☐ Wheat ☐ Bee Stings

☐ Latex ☐ Other: _____

How many times has your child had a reaction? ☐ < 3 ☐ 3 - 5 ☐ > 5

Age/date of last reaction and the allergen: _____

Symptoms: _____

How quickly did symptoms appear after exposure? _____

Severity (including the need for hospitalization): _____

Please check <u>ALL</u> symptoms that your child has experienced in the past:

Skin: ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling (face, arms, hands, legs)

Mouth: ☐ Itching ☐ Swelling (lips, tongue, mouth)

Abdominal: ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea

Throat: ☐ Itching ☐ Tightness ☐ Hoarseness ☐ Cough

Lungs: ☐ Shortness of breath ☐ Repetitive cough ☐ Wheezing

Heart: ☐ Weak pulse ☐ Loss of consciousness

Has an epinephrine injection (EpiPen, Auvi-Q) been given for a past allergic reaction? ☐ Yes ☐ No

If yes, how many times has epinephrine been administered? _____

Child's level of self-care:

Knows what foods to avoid	☐ Yes	☐ No
Asks about food ingredients	☐ Yes	☐ No
Reads and understands food labels	☐ Yes	☐ No
Tells an adult immediately after an exposure	☐ Yes	☐ No
Tells peers and adults about their allergy	☐ Yes	☐ No
Firmly refuses a problem food	☐ Yes	☐ No
Knows how to use emergency medication	☐ Yes	☐ No
Has self-administered emergency medication in the past	☐ Yes	☐ No

Please indicate your preference by selecting **ONE** of the following:

____ I will provide all of my child's food. He/she is **not to eat other snacks/treats at school unless I am present or have provided prior written approval** specific to the item.

____ My child knows about foods to avoid and **may eat snacks/treats provided by others**.

Parent/Guardian Signature: _____ Date: _____

School Nurse notes: _____

_____

_____

Nurse Signature: _____ Date: _____