Banks School District

Anaphylaxis/Allergy Parent Questionnaire

Please complete this form regarding your child's allergy. This information will be used to develop a health plan, if necessary, and shared with appropriate staff. Your input is extremely important. Thank you for your time.

Student: _____

Date of Birth: _____

History

1. To what is your child severely allergic?
   _____
2. Allergic reaction with: ☐Contact ☐Inhalation ☐Ingestion
3. How was this allergy diagnosed? ☐Blood Test ☐Skin Test ☐Exposure Age/Date of first reaction? _____
4. How many reactions have since been experienced? _____
5. Are the reactions worsening each time? _____
6. Has your child required treatment in an emergency department? If yes, please give date/age.
7. _____
8. Has an Epi-Pen ever been used on your child? _____
9. Does your child have a diagnosis of asthma? _____

Symptoms

10. Please check all that apply and describe severity of the symptoms your child experiences:

☐Difficulty breathing _____
☐Difficulty swallowing _____
☐Rash _____
☐Nausea /vomiting/diarrhea _____
☐Swelling – how much and where? _____
☐Other --- please describe _____

11. How soon after exposure do the symptoms appear?

_____

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Treatment/Plan

12. How is your child's reaction treated? ☐Epi-Pen ☐Antihistamine ☐Other: _____
13. Over the counter medication dose given?
    _____
14. Will your child have the above medication at school? ☐Yes ☐No
15. If your child has asthma, will an inhaler be available at school? ☐Yes ☐No
16. May the student sit at lunch tables with other students eating food containing the allergen?
    ☐Yes ☐No
17. Does the classroom need to be free from this allergen (i.e. peanut free)? ☐Yes ☐No
18. Medication at school is kept secure in the front office. Does the severity of the student's condition require self-carry? ☐Yes ☐No

(*Medication must be brought to school by parent in the original container. School medication authorization form(s) must completed and signed by parent/guardian. These forms can be found on the District website under "District>Student Services>Nursing Services" OR at the school front office.)*

Please feel free to share anything additional you would like us to know about your child:

Parent Signature: _____ Date: _____

Name of Health Care Provider: _____ Phone: _____

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Completed forms may be returned to the school office or Faxed to: (503) 324-6969. ATTN: District Nurse