



# ALVIN INDEPENDENT SCHOOL DISTRICT

## Questionnaire for a Parent of a Student with Allergy/Anaphylaxis

Please complete this form for your child's anaphylactic allergy, so school staff can plan effectively.

Student name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_ School Year \_\_\_\_\_

**If your child's anaphylactic allergy reaction is resolved and is no longer a medical concern, check below, sign and return the form.**

My child's anaphylactic allergy is resolved.

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

**Allergens:** (check all that apply)

**Name the specific allergen causing the reaction:**

- Peanuts
- Tree Nuts
- Fish/Shellfish
- Eggs
- Dairy
- Wheat
- Other

Specifically: \_\_\_\_\_  
 Specifically: \_\_\_\_\_  
 Specifically: Raw \_\_\_\_\_ Cooked \_\_\_\_\_  
 Specifically: \_\_\_\_\_  
 Specifically: \_\_\_\_\_  
 Specifically: \_\_\_\_\_

**My child has a food allergy reaction when he/she:**

- Eats a food or another food containing the food allergen
- Touches a surface contaminated with the food allergen
- Breathes odors from the food allergen while the food is being cooked or processed

**Symptoms of child's allergy reaction/intolerance include:** (check or circle all that apply)

- Mouth: Mild itching, tingling or swelling of the lips, tongue, mouth, drooling
- Skin: Hives, welts, itchy rash, swelling or flushing of the face
- Gut: Nausea, abdominal cramps/pain, vomiting, diarrhea
- Throat: Tightening of the throat, scratchy throat, hoarseness, hacking cough
- Lung: Shortness of breath, repetitive coughing, wheezing
- Heart: Weak pulse, low BP, fainting, pale, blueness
- Neuro: Disorientation, dizziness, loss of consciousness

**Onset of symptoms after ingestion/exposure:**

- Immediately
- Within 15 minutes
- Within one hour
- Up to two hours

**For peanut allergy:** Reading food labels all the time is important. If a label indicates the food item was made in a facility that also processes peanuts, my child MAY consume that food. \_\_\_\_ Yes \_\_\_\_ No

**For egg allergy:** My child CAN eat eggs that are cooked, such as in baked goods. \_\_\_\_ Yes \_\_\_\_ No



# **ALVIN INDEPENDENT SCHOOL DISTRICT**

## Questionnaire for a Parent of a Student with Allergy/Anaphylaxis

### **Anaphylactic Allergy Medications:**

My child's physician has ordered the following medications for my child's anaphylactic allergy:

- Antihistamine \_\_\_ Benadryl \_\_\_ Claritin \_\_\_ Zyrtec
- Epi-Pen/epinephrine
- Inhaler (Brand) \_\_\_\_\_

\*Refer to the allergy action plan for dosing directions. Your school nurse has a separate allergy action plan form that must be filled out and signed by the physician annually if medications are kept at school.

**Medications will be kept:** In the nurse's office \_\_\_ Yes \_\_\_ No  
Student will self carry \_\_\_ Yes \_\_\_ No

\*For self-carry, your school nurse has a separate form that is required and must be signed by the physician.

**School staff will call 911 WHEN the epi-pen is given. An ambulance will transport your child to the nearest hospital or emergency room for further care.**

I will bring a safe snack box for my child to use in the classroom and as a substitute for party treats.  
\_\_\_ Yes \_\_\_ No (Elementary ONLY)

### **I understand and agree to the following:**

1. It is the mutual responsibility of the parent and teacher to review party or field trip menus.
2. It is understood that food servers are taught how to prevent cross contamination during food preparation and when serving food in the lunch line.
3. It is the responsibility of the parent to review the lunch menu with their child and help them make appropriate choices.
4. It is understood that students are encouraged not to share snacks or utensils with each other.
5. It is understood that the parent will educate their child which foods may not be consumed.
6. It is understood that the parent will complete and sign this form annually, along with the allergy action plan and medication administration records.
7. It is understood that the parent will provide the emergency medications needed at school and pick them up at the end of the school year.
8. It is the responsibility of the parent to notify the school nurse of any changes in the health plan of their child.

### **PARENT PERMISSION**

I verify that the above information is correct. I give my permission for the school nurse to share this information with school staff on a need-to-know basis.

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Mother (print name) \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Father (print name) \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**\*All information verified.** School nurse signature \_\_\_\_\_ Date: \_\_\_\_\_