Allergic Reaction Parent Questionnaire

Name: _____DOB: _____ Grade ____ Teacher_____
Gender: ☐ M ☐ F

Allergy_____ Date Completed: _____

Please complete both sides of this form and return to the Health Office.
(*The following information will be shared with necessary school personnel. It will help us take care of your child at school.*)

Person to Contact	Relationship	Phone (Work/Home/Cell)	Phone (Work/Home/Cell)
_____	_____	_____	_____
_____	_____	_____	_____

Health Care Provider	Clinic	Telephone
_____	_____	_____

Health Insurance: ☐ Private ☐ Medical Assistance ☐ MN Care ☐ No Insurance

1. Has the student been diagnosed with allergies/anaphylactic reactions by a health care provider? ☐ Yes ☐ No
2. Student's age at diagnosis of allergies/anaphylaxis? _____
3. Does your child have asthma/breathing problems? ☐ Yes ☐ No
4. Please CHECK what usually triggers (starts) your child's allergy attack/episode:

   ☐ Peanuts ☐ Tree Nuts ☐ Insect Stings *(kind:_____)*
   ☐ Seafood ☐ Eggs ☐ Animal *(list: _____)*
   ☐ Latex ☐ Soy ☐ Medications *(list _____)*
   ☐ Fish ☐ Dairy Products *(list _____)*
   ☐ Other _____
5. How soon after contact does the student react? _____ Minutes _____ Hours _____ Days
6. When was the last time that your child was treated for an allergic reaction? _____
7. In the past, how often has the student been treated in the emergency room?
   ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ More than 3 times
8. When was the last time that your child received Epinephrine *(EpiPen or TwinJet)* for an allergic reaction? _____
9. Does your child have any early-warning signs (physical and/or emotional changes) that indicate your child is starting to have an allergic reaction?_____
10. Please circle this student's usual signs/symptoms of an allergic reaction/anaphylaxis:

Symptoms of Allergic Reaction	Mouth	Itching, swelling of lips, tongue, or mouth
	Throat*	Itching, sense of tightness in throat, hoarseness, hacking cough
All symptoms can become life-threatening. Severity of symptoms can quickly change.	Skin	Hives, itching, rash, flushing, swelling of face or extremities
	Gut	Nausea, abdominal cramps, vomiting, diarrhea
	Lung*	Shortness of breath, repetitive coughing, wheezing
	Heart*	"Thready" pulse, "passing out"

11. Does this student recognize these signs/symptoms? ☐ Yes ☐ No
12. Does this student know how to avoid allergens (causes of allergic/anaphylactic reactions)? ☐ Yes ☐ No
13. Please list the medications your child takes to treat allergies *(everyday medication and medication taken when needed)*

Medication Name	How Much	When is it Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Please list anything else you use for your child's allergies *(home remedies, etc)*:_____

_____

If a medication is to be given at school, a Medication Consent Form must be completed yearly or if changes are needed. A prescribing health care professional may authorize self-administration if the student is deemed capable by both the health care professional and the Licensed School Nurse. The medication must be in the original labeled container, not be expired and be properly labeled.

14. If your child has an EpiPen or TwinJect prescribed:
    - Has he/she received training on how to self-administer? ☐ Yes ☐ No
    - Has he/she ever self-administered? ☐ Yes, when_____ ☐ No
    - An Epipen or Twinject may be given by staff that has been trained by the LSN
15. Please add anything else that you would like the Health Office to know about your child's allergies?

_____

_____

Authorization

- The purpose of this form is to facilitate communication between the health care provider ad the Health Office as it relates to your child's allergy so as to meet your child's need in the school setting and to ask for your consent, or authorization, to request information from your health care provider and to release information to your health care provide from St. Croix Preparatory Academy professional staff.
- I agree that my child's health care provider may release information to the SCPA professional staff, and/or request information from SCPA professional staff as it relates to my child's allergy.
- I agree that SCPA professional staff may release information to the health care provider and/or request information from the health care provider as it relates to my child's allergy.
- Legally, you may refuse to sign. Services are not conditioned up on the release of information.
- I understand that the consent takes effect the day that I sign it and expires one year form the date of my signature.
- I understand that I may revoke this consent at any time by giving written notification.
- It is the practice SCPA not to re-disclose records without consent.
- A photocopy/fax of this consent, which has not been altered, will be treated in the same manner as the original
- You may ask for a copy of the records disclosed.

_____ _____

Parent/Guardian Signature Date

FOR HEALTH OFFICE USE ONLY

Reviewed by LSN_____ Date _____ Date_____ Date_____

Verbal communication with parents: ☐ YES Date_____ ☐ NO Date(s) Attempted_____