

INDEPENDENT SCHOOL DISTRICT 196
Rosemount-Apple Valley-Eagan Public Schools
Educating our students to reach their full potential

Series Number 506.2.3P Adopted September 1998 Revised July 2012

Title Student Allergy Information

Student name _____ Date of birth _____

Parent/guardian _____ Today's date _____

Home phone _____ Work _____ Cell _____

Primary healthcare provider _____ Phone _____

Allergist _____ Phone _____

1. Does your child have an allergy diagnosis from a healthcare provider? No Yes

2. Does your child have a history of asthma? No Yes

3. History and Current Status

What is your child allergic to?

- | | |
|---|--|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Fish |
| <input type="checkbox"/> Tree nuts
(walnuts, pecans, etc.) | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Milk | <input type="checkbox"/> Insect stings |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Wheat | <input type="checkbox"/> Chemicals _____ |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Vapors _____ |
| <input type="checkbox"/> Other _____ | |

Age of child when allergy first discovered _____

How many times has your child had a reaction?

- never once more than once, explain:

Explain past allergic reaction(s) _____

Symptoms _____

Are the food allergy reactions:

- staying the same getting better becoming worse

4. Trigger and Symptoms

What are the early signs and symptoms of your child's allergic reaction? (Be specific; include things your child might say.)

How does your child communicate his/her symptoms? _____

How quickly do symptoms appear after exposure of allergen? secs. _____ mins. _____ hrs. _____ days _____

Please check the symptoms that your child has experienced in the past:

- | | | | | | |
|-------------------|--|---|--|-------------------------------------|---|
| Skin: | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching | <input type="checkbox"/> Rash | <input type="checkbox"/> Flushing | <input type="checkbox"/> Swelling (face, arms, hands, legs) |
| Mouth: | <input type="checkbox"/> Itching | <input type="checkbox"/> Swelling (lips, tongue, mouth) | | | |
| Abdominal: | <input type="checkbox"/> Nausea | <input type="checkbox"/> Cramps | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | |
| Throat: | <input type="checkbox"/> Itching | <input type="checkbox"/> Tightness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Cough |
| Lungs: | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Repetitive cough | <input type="checkbox"/> Wheezing | | |
| Heart: | <input type="checkbox"/> Weak pulse | <input type="checkbox"/> Loss of consciousness | | | |

5. Treatment

How have past reactions been treated? _____

How effective was the child's response to treatment? _____

Was there an emergency room visit? No Yes, explain _____

Was the student admitted to the hospital? No Yes, explain _____

What treatment or medication has your healthcare provider recommended for use in an allergic reaction?

Has your healthcare provider given your child a prescription for medication? No Yes

Have you used the treatment or medication? No Yes

Please describe any side effects or problems your child has had in using the suggested treatment: _____

6. Self Care

- Is your child able to monitor and prevent their own exposures? No Yes
- Does your child:
 - Know what foods to avoid? No Yes
 - Ask about food ingredients? No Yes
 - Read and understand food labels? No Yes
 - Tell an adult immediately after an exposure? No Yes
 - Wear a medical alert bracelet, necklace, watchband? No Yes
 - Tell peers and adults about the allergy? No Yes
 - Firmly refuse a problem food? No Yes
- Does your child know how to use emergency medication? No Yes _____
- Has your child ever administered their own emergency medication? No Yes _____

7. Family/Home

- Does your child carry epinephrine in the event of a reaction? No Yes
- Has your child ever needed to administer that epinephrine? No Yes
- Do you feel that your child needs assistance in coping with his/her allergy? No Yes
- How do you feel your family as a whole is coping with your child's allergy? _____

8. General Health

- How is your child's general health other than having an allergy? _____
- Does your child have other health conditions? _____
- Hospitalizations? _____
- Please add anything else you would like the school to know about your child's health: _____

9. Notes: _____

This procedure will be reviewed and revised when deemed appropriate by the school nurse (LSN) or parent/guardian.

Reviewed by LSN _____ Date _____

Parent/guardian signature _____ Date _____

Reviewed by LSN _____ Date _____

Parent/guardian signature _____ Date _____

Reviewed by LSN _____ Date _____

Parent/guardian signature _____ Date _____

Adapted with permission – Washington State Guidelines for Anaphylaxis and National Association of School Nurses