FORM A

ARLINGTON HEIGHTS SCHOOL DISTRICT 25

# ANNUAL SEVERE ALLERGY PARENT SURVEY

## TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Student (Last, First): _____

School:_____ Grade : _____

**I understand it is my responsibility to renew this form before each school year and any time my child's medical needs change.**

Parent/Guardian Name: _____Date. _____

## ALLERGEN

My child is allergic to: _____

My child reacts to the allergen when they: ☐eat it ☐inhale it ☐touch it ☐other_____

My child had their first allergic reaction at age: _____

My child's most recent allergic reaction was on this date: _____

### Describe the symptoms of an allergic reaction that your child had in the past:

- ☐ itching, tingling, or swelling of lips, tongue, mouth
- ☐ hives, itchy rash, swelling of the face or extremities
- ☐ nausea, abdominal cramps, vomiting, diarrhea
- ☐ tightening of throat, hoarseness, hacking cough
- ☐ shortness of breath, repetitive coughing, wheezing
- ☐ fainting, pale, blueness
- ☐ other _____

### Allergic Reaction Treatment:

Has your child seen a physician for this allergy? ☐no ☐yes

If yes, describe the medical treatment provided: _____

Physician Name: _____

Has your child received care in the emergency room for an allergic reaction? ☐no ☐yes

If yes, describe the medical treatment provided: _____

How do you treat allergic reactions at home? _____

Does your child have an epinephrine auto-injector at home? ☐no ☐yes

If yes, does your child know how to use the epinephrine auto-injector? ☐no ☐yes

Any other suggestions for school staff to do in response to your child having an allergic reaction? _____

_____

May we share your child's allergy information with their classmates? ☐no ☐yes