Arlington Heights School District 25

FORM A

Annual Severe Allergy Survey – Parent Information **SCHOOL YEAR_____**

Please provide us with information about your child's allergies. Annually, please update this form with new information. If there are questions, your school nurse will follow up with you.

Student Name_____ Grade_____

1. Please indicate what your child is allergic to by checking the appropriate box.

   _ peanuts
   _ tree nuts
   _ milk
   _ bee sting
   _ latex
   _ other _____

2. At what age did your child experience their first allergic reaction?

3. Please describe the signs and symptoms of the allergic reaction he/she has 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_____

4. Has your child seen a doctor for this allergy?
   _ Yes _ No
   If yes, what medical treatment was provided and by whom?

5. Has your child been seen at an emergency room because of an allergic reaction, and if so, what medication was given?

6. When was the last time your child had an allergic reaction?

7. How do you treat allergic reactions at home?

8. Does your child have an epinephrine auto-injector at home?
   _ Yes _ No

9. If yes, does your child know how to use the epinephrine auto-injecto?
   _ Yes _ No

10. Please indicate when your child reacts to the allergen by checking the appropriate box
    _ eats it _ inhales it
    _ touches it _other_____

11. May we share your child's allergy information with his/her classmates?
    _ Yes - No

12. What do you think would be helpful for school staff to do in response to your child having an allergic reaction?

Parent Signature_____ **Date**_____