

STUDENT WITH FOOD ALLERGY Parent Questionnaire

Student's Name _____ Grade _____ Homeroom _____
 Name of Student's Doctor (for allergies) _____ Ph. _____

The following information will help the school nurse and school personnel meet the health needs of your child while he/she is at school. Please answer the following questions to the best of your ability.

	Allergy #1	Allergy #2	Allergy #3
What food is your child allergic to?			
On a scale of 0-10 with 0 being "Mild" and 10 being "Severe," how would you rate your child's food allergy?			
At what age did your child start experiencing this food allergy?			
How do you know that your child is allergic to this food?	<input type="checkbox"/> Reaction after exposure to food <input type="checkbox"/> Prick skin testing <input type="checkbox"/> Blood testing <input type="checkbox"/> Family history	<input type="checkbox"/> Reaction after exposure to food <input type="checkbox"/> Prick skin testing <input type="checkbox"/> Blood testing <input type="checkbox"/> Family history	<input type="checkbox"/> Reaction after exposure to food <input type="checkbox"/> Prick skin testing <input type="checkbox"/> Blood testing <input type="checkbox"/> Family history
When was the last time your child ate this food?			
How soon after being exposed to this food do your child's symptoms start?			
How long do your child's symptoms last?			
What symptoms does your child have when exposed to this food? (check all that apply)	<input type="checkbox"/> Itching/tingling (where _____) <input type="checkbox"/> Swelling (where _____) <input type="checkbox"/> Hives, itchy red rash <input type="checkbox"/> Tightening of throat/ hoarseness <input type="checkbox"/> Trouble breathing <input type="checkbox"/> Cough/ wheezing <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Dizziness or Lightheadedness <input type="checkbox"/> Anxiety/ sense of impending doom <input type="checkbox"/> Other: Describe _____ _____	<input type="checkbox"/> Itching/tingling (where _____) <input type="checkbox"/> Swelling (where _____) <input type="checkbox"/> Hives, itchy red rash <input type="checkbox"/> Tightening of throat/ hoarseness <input type="checkbox"/> Trouble breathing <input type="checkbox"/> Cough/ wheezing <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Dizziness or Lightheadedness <input type="checkbox"/> Anxiety/ sense of impending doom <input type="checkbox"/> Other: Describe _____ _____	<input type="checkbox"/> Itching/tingling (where _____) <input type="checkbox"/> Swelling (where _____) <input type="checkbox"/> Hives, itchy red rash <input type="checkbox"/> Tightening of throat/ hoarseness <input type="checkbox"/> Trouble breathing <input type="checkbox"/> Cough/ wheezing <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Dizziness or Lightheadedness <input type="checkbox"/> Anxiety/ sense of impending doom <input type="checkbox"/> Other: Describe _____ _____
Does your child take medication for these symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes- please list _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes- please list _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes- please list _____ _____
Does your child have an Epinephrine Auto-injector prescribed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

1. Does your child have any other allergies or asthma? (please list) _____
2. How often does your child see his/her doctor for routine allergy evaluations? _____
3. When was his/her last appointment? _____
4. When was your child's last episode of food allergy symptoms? _____
5. How many times has your child been treated in the ER or hospitalized for an allergic reaction? _____
6. If prescribed, where do you want your child to keep his/her epinephrine auto-injector during the school day?
 Health Office With him/her
7. Has your child received education about how to recognize symptoms of allergic reaction?
 Yes _____ No _____
8. Has your child received education about how to self-administer his/her epinephrine autoinjector?
 Yes _____ No _____
9. Does your child wear a Medic Alert bracelet or something similar to identify him/her as having food allergies?
 Yes _____ No _____
10. Does your child need any special considerations related to his/her food allergy(ies) while at school? (Check all that apply and describe briefly)
 Modified snacks _____
 Modified lunch seating _____
 Emotional or behavior concerns _____
 Special considerations on field trips _____
 Other _____
11. Is there anything else you would like for school personnel to know about you child's food allergy(ies)?

May this information be shared with the classroom teacher(s), bus driver(s) and other appropriate school personnel? Yes _____ No _____

If you wish to personally discuss your child's food allergy with the school nurse, you may reach the school nurse at:

Nurse's Name _____ **Ph.** _____ **Days** _____

If the school nurse needs to contact you to review this information please list your contact information:

Parent's Name(s) _____ Ph. (H) _____ (W) _____

Signature of Parent/Guardian Completing Questionnaire

Date