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?	☐ Reaction after exposure to food ☐ Prick skin testing ☐ Blood testing ☐ Family history	☐ Reaction after exposure to food ☐ Prick skin testing ☐ Blood testing ☐ Family history	☐ Reaction after exposure to food ☐ Prick skin testing ☐ Blood testing ☐ 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 you child's symptoms last?			
What symptoms does your child have when exposed to this food? (check all that apply)	☐ Itching/tingling (where _________) ☐ Swelling (where _________) ☐ Hives, itchy red rash ☐ Tightening of throat/ hoarseness ☐ Trouble breathing ☐ Cough/ wheezing ☐ Abdominal cramps ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Dizziness or Lightheadedness ☐ Anxiety/ sense of impending doom ☐ Other: Describe __________________ __________________	☐ Itching/tingling (where _________) ☐ Swelling (where _________) ☐ Hives, itchy red rash ☐ Tightening of throat/ hoarseness ☐ Trouble breathing ☐ Cough/ wheezing ☐ Abdominal cramps ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Dizziness or Lightheadedness ☐ Anxiety/ sense of impending doom ☐ Other: Describe __________________ __________________	☐ Itching/tingling (where _________) ☐ Swelling (where _________) ☐ Hives, itchy red rash ☐ Tightening of throat/ hoarseness ☐ Trouble breathing ☐ Cough/ wheezing ☐ Abdominal cramps ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Dizziness or Lightheadedness ☐ Anxiety/ sense of impending doom ☐ Other: Describe __________________ __________________
Does your child take medication for these symptoms?	☐ No ☐ Yes- please list __________________ __________________	☐ No ☐ Yes- please list __________________ __________________	☐ No ☐ Yes- please list __________________ __________________
Does your child have an Epinepherine Auto-injector prescribed?	☐ No	☐ No	☐ No

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	☐ Yes	☐ Yes	☐ 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