MUMFORD ISD
SEVERE ALLERGY QUESTIONNAIRE

Student's Name: _____ ***Grade:*** _____

Severe Allergies *(be specific):* _____

Date of child's last allergic episode? ___ / ___ / ___ *___ Never had an allergic episode*

*What happened?*_____

Diagnosed by skin/blood testing? YES / NO *Physician's Name:* _____

Reaction can occur by (check all that apply): ◯ *Ingestion* ◯ *Contact* ◯ *Inhalation* ◯ *Unknown*

How quickly do symptoms appear after exposure? (circle one) *seconds / minutes / hours / days*

What are the early signs and symptoms of this child's allergic reaction?_____

Check any symptoms that have occurred during an allergic episode:

◯ *Itchy mouth* ◯ *Swelling* ◯ *Itchy throat* ◯ *Tight throat* ◯ *Trouble swallowing* ◯ *Hoarseness*

◯ *Hives* ◯ *Rash* ◯ *Nausea* ◯ *Vomiting* ◯ *Diarrhea/cramps* ◯ *Difficulty breathing*

◯ *Wheezing* ◯ *Cough* ◯ *Loss of consciousness* ◯ *Other:*_____

Please answer the following:

1. *Has your child ever had to use epinephrine for a reaction? YES / NO*
2. *Has child ever been hospitalized for an allergic episode? YES / NO* *If "yes", when?*_____
3. *Can your child sit near someone eating the allergen? YES / NO*
4. *Can your child eat things processed in a facility that also processes the allergen? YES / NO*
5. *Does your child know what the allergen looks like and how to avoid it? YES / NO*
6. *Does your child have Asthma? YES / NO*
7. *Does the student know to tell an adult immediately after exposure? YES / NO*
8. *Does your child know how to use emergency medication? YES / NO*

What do you do at home (accommodations, diet restrictions, substitutions)? _____

_____

What medications have been ordered by your physician to be given in the event of allergic reaction?

_____

*Additional Notes:*_____

_____

SIGNATURE OF PARENT/GUARDIAN:_____ ***DATE:***_____

PARENT/GUARDIAN NAME (PRINTED)_____***PHONE:***_____