Environmental Allergy Information Form

Student Name:_____ Date of Birth: _____

Parent/Guardian:_____ Phone:_____

Do you think your student's allergy is life threatening? ___ No ___Yes
Does your student's health care provider (HCP) believe the allergy is life threatening? ___No ___Yes
(If the answer is yes to either question, please contact school nurse as soon as possible)

History and Current Status

What has your student reacted to?_____
How many times has your student had a reaction? ____Never ____Once ____More than once, please describe: _____
When was the last reaction? _____
Are the reactions: ____Staying the same ____Getting worse ____Getting better
Has your student ever needed treatment at a clinic or hospital for an allergic reaction? ____No ____Yes Please Describe:_____
Has your student ever received or used an Epi-pen or other injection as treatment? ____No ____Yes Please Describe:_____

Triggers and Symptoms

What are the signs and symptoms of your student's reaction? (Be specific, include things your child may say) _____
How quickly do the symptoms appear after exposure? ____Seconds ____Minutes ____Hours ____Days

Treatment

Does your student know how to avoid the allergen? ____No ____Yes
What do you do at home to treat a reaction?
_____
What treatment or medication has your HCP recommended for an allergic reaction? ____None
_____
Have you used the treatment of medication? ____No ____Yes
Does your student know how to use the treatment or medication? ____No ____Yes

If medication is to be available at school? Have you completed a medication authorization form?
____Yes
____No, I need a form, have it completed by my HCP, and return it to the school

If medication is needed, have you brought the medication and/or treatment supplies to school?

____Yes
____No, I need to get the medication and bring it to school

What would you like the school to do in case of an exposure and/or reaction?_____
_____

Parent/Guardian Signature:_____ Date:_____