

Providence Academy Health Office • Allergic Reaction Questionnaire

Student _____ Date of Birth _____ Grade _____
School _____ School Year _____

Health History Pertaining to Allergies

Allergen: _____

Has your child been diagnosed with allergies/anaphylactic reactions by a health care provider? Yes No

Has your child been prescribed an EpiPen? Yes No

Child's age and symptoms at diagnosis: _____

Has your child been treated with epinephrine or seen at the emergency room? Yes No

If yes, how often and at what age(s)? _____

Are there any early warning signs or symptoms of an impending reaction and does your child recognize these?

Accommodations

Is your child capable of recognizing and avoiding their allergens? Yes No

If no, which of the following would you request for your child?

In the **classroom**:

- Child will have no snacks unless provided by parents/guardian.
- Parents will be asked to **avoid sending known allergens in any shared snacks** (birthday treat, etc.)
- Notice will be sent to parents of other classmates asking that they avoid sending food containing known allergens for **their child's snacks** at school.
- Teacher will review lesson plans and projects and modify as needed to protect the student.
- NO ACCOMMODATIONS NEEDED

In the **cafeteria**:

- Child will have students with hot lunch sitting on either side of them.
- NO ACCOMMODATIONS NEEDED

On the **bus**:

- Child will sit in the first two rows.
- Parent will introduce student to driver and show where EpiPen is located.
- NO ACCOMMODATIONS NEEDED

Electronically approved and signed by:

Parent/Guardian Signature _____ Date _____

Management Plan - See Attached Anaphylaxis Action Plan

*A copy of the Anaphylaxis Action Plan will be kept in the Health Office and teacher substitute folder. This plan will be given to staff members involved with the student.

EpiPen locations: Health Office Classroom Carried by teacher
 With student _____ (specify location)

Licensed School Nurse _____ Phone # _____