Houston County School District
Health Related Services

Allergy Questionnaire and Plan

Student: _____ **DOB**: _____ Valid **for school year:** _____

Please complete this form for your child's allergy so staff can plan effectively for your child's care while at school. **Please note: if your child is participating in activities before and after the school day including after school care, extracurricular activities/trips, athletics, or camps, it is imperative that YOU inform the supervising adults of your child's allergies and special needs. This is necessary because the school may not be aware of all activities the student is participating in beyond the normal school day/year.**

Do you plan for your child to receive school prepared meals? Yes *___No ___
If Yes, an additional Meal Modification form must be completed for food allergies accommodations

If your child's anaphylactic allergy reaction is resolved and is no longer a medical concern, check on the line, sign and return the form.

_____My child's anaphylactic allergy is resolved.

PARENT SIGNATURE: _____ **DATE:** _____

ALLERGIES: Check all that apply. Name the specific food causing the reaction.

- Nuts(list):_____ _____
- Plants(list):_____
- Seafood(list): _____
- Fruit(list):_____ _____
- Dairy Products(list): _____
- Insects(list):_____
- Other:_____

My child has the reaction when he/she:

- Eats a food or another food containing the food allergen.
- Touches a surface contaminated with oils from the allergen.
- Breathes odors from the allergen.

SYMPTOMS of child's allergy reaction/intolerance include:

- Nausea and vomiting
- Cramping and/or abdominal pain
- Facial swelling, itching, welts or hives
- Swelling of the lips, nose, tongue or throat
- Respiratory changes: difficulty breathing, wheezing or continuous coughing
- Inability to speak or swallow
- Flushed face
- Drooling
- Complains that the throat feels tight, scratchy, or different in some way
- OTHER – DESCRIBE: _____

ONSET OF SYMPTOMS:

- ☐ Immediately
- ☐ Within 15 minutes
- Within one hour
- Up to two hours

Student: _____ **DOB**: _____ Valid **for school year:** _____

ANPHYLACTIC ALLERGY ACTION PLAN

- My child is aware of signs and symptoms of an allergic reaction and knows to tell an adult. They usually state they feel:_____
- My child carries their emergency medication with them and can self-administer.
- My child will leave their emergency medication in the school medical clinic.
- I will bring a safe snack box for my child to use in the classroom and as a substitute for party treats.
- My child can eat at any table in the lunchroom with their class. My child is able to self-monitor the area for safety and make a choice of where to sit to prevent an exposure.
- My child needs to be assigned a seat at an allergy safe table in the cafeteria.
- Parent will provide the following emergency medications (HRS-29C Required) _____

_____

*School stock **EPI-PEN can be given in emergency situations. Staff will call 911 WHEN the EPI-PEN is given. EMT's will take your child to the nearest local hospital emergency room for more care.**

Memorandum of Understanding

1. It is the mutual responsibility of the parent and teacher to review party or field trip menus.
2. It is the responsibility of the parent to review the cafeteria menu with their child.
3. It is understood that this student should not share snacks or eating utensils.
4. It is understood that the parent will complete and sign this form annually.
5. It is understood that the parent will provide the emergency medications needed at school and sign the Parent/Physician Medication Consent Form.
6. It is the responsibility of the parent to notify the district nurse of changes in health plan.

_____

PARENT PERMISSION

I verify that the above information is correct. I give my permission to share this information with staff on a need to know basis. I give consent to exchange medical information with the student's physician as needed.

The information is **valid for ONE school year**. **Annual parent signature is required.**

Parent/guardian Signature: _____ Date: _____
Contact Phone #: _____ Cell #: _____
Physician Name and Number: _____
Emergency Contact #: _____ Relationship: _____