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| STUDENT  Student Name and DOB |  |
| ALLERGENS  Tell me what your student has had a severe allergic reaction to. |  |
| TRIGGERS  Tell me about specific allergic triggers for your child? ( please specify) | ☐ Exercise ☐ Heat ☐ Cold |
| TYPE OF SYMPTOMS  Tell me about what type of symptoms your child experienced. | ☐ Facial swelling ☐ Throat swelling ☐ Hives or rash  ☐ Difficulty breathing or swallowing ☐ Hoarseness  ☐ Burning sensation ☐ Changes in skin color  ☐ Sneezing/wheezing/coughing ☐ Abdominal pain  ☐ Nausea/ vomiting/ diarrhea ☐ Other (describe below:) |
| ONSET  When was your child’s first reaction? |  |
| FREQUENCY  How often does your child experience severe allergic reactions? |  |
| SENSITIVITY  How does your child’s reaction occur? | ☐ Direct Contact ☐ Inhalation ☐ Ingestion only ☐ Sting |
| CO-OCCURRING CONDITIONS  Does your child have asthma or another immune mediated condition? |  |
| MEDICATION  What has your child been prescribed for allergic reactions? |  |
| HISTORY  Has your child required emergency care or hospitalization secondary to a severe allergic reaction? |  |
| PROVIDER  Who is your child’s allergist or immunologist? |  |
| ACCOMODATIONS  Does your child require any accommodations related to allergies? |  |
| RESTRICTIONS  Does your child have any restrictions related to allergies? |  |
| FORM COMPLETION  Who completed this form? Date? |  |