|  |  |
| --- | --- |
| STUDENTStudent Name and DOB |   |
| ALLERGENSTell me what your student has had a severe allergic reaction to. |  |
| TRIGGERSTell me about specific allergic triggers for your child? ( please specify) |  ☐ Exercise ☐ Heat ☐ Cold |
| TYPE OF SYMPTOMSTell 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:) |
| ONSETWhen was your child’s first reaction? |   |
| FREQUENCYHow often does your child experience severe allergic reactions? |  |
| SENSITIVITYHow does your child’s reaction occur? | ☐ Direct Contact ☐ Inhalation ☐ Ingestion only ☐ Sting |
| CO-OCCURRING CONDITIONSDoes your child have asthma or another immune mediated condition? |  |
| MEDICATIONWhat has your child been prescribed for allergic reactions? |  |
| HISTORYHas your child required emergency care or hospitalization secondary to a severe allergic reaction? |  |
| PROVIDERWho is your child’s allergist or immunologist? |  |
| ACCOMODATIONSDoes your child require any accommodations related to allergies? |  |
| RESTRICTIONSDoes your child have any restrictions related to allergies? |  |
| FORM COMPLETIONWho completed this form? Date? |  |