Everett Public Schools
Health Services

Allergic Reaction Questionnaire

Student Name: ______________________ Date of Birth: ______________________
School: ______________________ School Year: ______________________
Student Number: ______________________ Grade: ______________________
Parent/Guardian: ______________________ Phone: ________________
Health Care Provider: ____________________ Phone: _____________Fax___________

Life Threatening Allergy to: ____

If YES, what medications have been prescribed? ____

(Washington State requirements regarding life threatening conditions must be met prior to attending school .WAC 180-38).

Non Life Threatening Allergy to: ____

Has your child seen a Health Care Provider (LHCP) regarding this condition?______When?____
Did the LHCP perform a skin test? ____ RAST (blood) test? ____
Does your child have a history of asthma? ____
Is this allergy with ingestion only or skin contact, airborne exposure? _____________________
____
Brief history and dates of past reactions____
____
____

What symptoms has your child had?

Mouth:
___itching ___swelling ___tingling of the lips, tongue or mouth ___blueness around lips

Throat:
___itching and/or sense of tightness in the throat ___hoarseness and/or hacking cough

Skin:
___hives ___ itching rash ___ swelling about the face or extremities

Abdomen:
___nausea ___abdominal cramps ___vomiting ___ diarrhea

Lungs:
___shortness of breath ___ repetitive cough ___ wheezing

Heart:
___weak pulse ___dizziness ___fainting

Any other concerns that school administrators or RN's should be aware of that may impact your child's educational program or school experience and would be important information in the event of an accident, injury or illness at school? ____
____
____

Parent/Guardian Signature______________________________ Date______________________