EVERETT PUBLIC SCHOOLS

RN Reviewed
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(For office use only)

Allergy Questionnaire

This form is to be filled out by the parent/guardian of all students with an allergy indicated on their Annual Health History. Once completed, please return it to the Health Room.

Student's Name: _____ **Student ID #:** _____
School: _____ **Student DOB:** _____ **Student Grade:** _____

☐ My child has a Life-Threatening Allergy to: _____

Allergy is: ☐Contact ☐ Ingestion ☐Airborne ☐ Sting/bite ☐ Medication
Brief History of past reactions: _____
_____
Has your child seen a licensed health care provider (LHCP) regarding this condition? ☐Yes ☐ No
Did the LHCP perform a skin test? ☐Yes ☐ No **RAST (blood) test?** ☐Yes ☐ No
Does your child have a history of a previous reaction? ☐Yes ☐ No **Date:** _____
Does your child have a history of Asthma? ☐Yes ☐ No
My child experiences the following allergy symptoms:

☐ Mouth/Throat Itching	☐ Shortness of breath/Wheezing	☐ Dizziness
☐ Throat swelling or tightness	☐ Skin Hives	☐ Fainting
☐ Tingling of lips, tongue or mouth	☐ Itching rash	☐ Nausea or vomiting
☐ Repetitive cough	☐ Facial/Extremity Swelling	☐ Abdominal cramping
☐ Hoarseness and or hacking cough	☐ Weak Pulse	☐ Diarrhea

For Food Allergies Only

☐ My child **MUST ALWAYS** sit at an Allergy Aware Table
☐ My child **can CHOOSE** whether or not to sit at an Allergy Aware Table.

☐ My child has a Non-Life-Threatening Allergy to: _____

Brief History of past reactions: _____
_____
Has your child seen a licensed health care provider (LHCP) regarding this condition? ☐Yes ☐ No
Does your child take medication to help with this allergy? ☐Yes ☐ No **Name of Medication:** _____
Does your child need medication at to school to help with this allergy? ☐Yes ☐ No
My child experiences the following allergy symptoms:

☐ Mouth/Throat Itching	☐ Hives	☐ Skin Hives
☐ Hoarseness and or Hacking cough	☐ Itching Rash	☐ Nausea or vomiting
☐ Red itchy eyes	☐ Facial/Extremity Swelling	☐Abdominal cramping

☐ My child has NO Allergy: ☐ Marked in error on Annual Health History ☐ Other:_____

I understand:

- If my child has a life-threating allergy requiring epinephrine and other rescue medication(s), additional conditions must be met prior to my student attending school as outlines in WAC 180-38, including but not limited to a completed Medication Authorization Form and all medication(s) ordered.
- If my child's medical condition changes, such that their allergy becomes more severe and or life-threatening, I will notify their school immediately.

_____ _____ _____
➢ Parent/Guardian Name Parent/Guardian Signature Date