Food/Latex Allergy Parent Questionnaire

Student Name: _____ Date of Birth: _____Date:_____

Parent/Guardian: _____Phone:_____Cell/work:_____

Name of Health Care Provider treating food/latex allergy: _____Phone:_____

Do you think your child's food/latex allergy may be life-threatening**?** ☐ No ☐ Yes
(If yes, please see the school nurse as soon as possible).

History and Current Status

Check the allergens that have caused a reaction:

☐ Peanuts ☐ Fish/shellfish ☐ Eggs ☐ Milk ☐ Latex
☐ Peanut or nut oils ☐ Soy products ☐ Tree nuts (walnuts, almonds, pecans, etc.)
☐ Others: _____

How many times has your student had a reaction? ☐ Never ☐ Once ☐ More than once, explain: _____

_____

When was the last reaction? _____

Are the food/latex allergy reactions: ☐ Staying the same ☐ Getting worse ☐ Getting better

Triggers and Symptoms

What has to happen for your student to react to the problem allergen? *(Check all that apply)*
☐ Eating foods ☐ Touching foods ☐ Smelling foods ☐ Other, please explain: _____

_____

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)*

_____

How quickly do signs and symptoms appear after allergen exposure? ___ Seconds ___Minutes ___ Hours ___Days

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction? ☐ No ☐ Yes

Explain: _____

Does your student understand how to avoid foods/latex that cause allergic reactions? ☐ No ☐ Yes

What treatment or medication has your health care provider recommended for use in an allergic reaction?

_____

Have you used the treatment? ☐ No ☐ Yes

Does your student know how to use the treatment? ☐ No ☐ Yes

Please describe any side effects or problems your child had in using the suggested treatment: _____

_____

What do you want us to do at school to help your student avoid problem foods/latex?: _____

_____

- Do you intend for your child to eat school provided meals? ☐No ☐ Yes
  If yes, please have Primary care provider complete diet order form and return to start of school.
- Is medication to be available at school? ☐No ☐ Yes
  If yes, Health Care Provider and parent must complete Authorization for Administration of Medication form and return prior to start of school.
- If medication is needed at school, please bring the medication/treatment supplies prior to start of school.

I give consent to share, with the classroom, that my child has a life-threatening food allergy. ☐No ☐ Yes

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This information may be used to create an individualized plan for your student and will be shared with staff on a need to know basis.

Parent/Guardian Signature:_____ Date: _____