SEVERE ALLERGY QUESTIONNAIRE

McFarland School District Health Services

5101 Farwell Street – McFarland, WI 53558 – 608-838-4679

HEALTH OFFICE →	**MHS:** 608-838-4682	**IMMS:** 608-838-4672	**WIS:** 608-838-4673	**CEPS:** 608-838-4674
FAX →	**MHS:** 608-838-4562	**IMMS:** 608- 838-4588	**WIS:** 608-838-4613	**CEPS:** 608-838-4503

Date: _____

STUDENT LAST NAME _____ **FIRST NAME** _____ **MIDDLE NAME** _____ **GRADE** _____

DATE OF BIRTH (MM/DD/YYYY) _____ **HOME PHONE** _____ **HOMEROOM** _____

ADDRESS CITY, STATE _____ **ZIP** _____

PARENT/GUARDIAN NAME _____ **WORK PHONE** _____ **CELL PHONE** _____

PARENT/GUARDIAN NAME _____ **WORK PHONE** _____ **CELL PHONE** _____

EMERGENCY CONTACT NAME _____ **WORK PHONE** _____ **CELL PHONE** _____

STUDENT'S PHYSICIAN _____ **CLINIC PHONE** _____ **CLINIC FAX** _____

PREFERRED HOSPITAL IN THE EVENT OF TRANSPORT _____

I will provide medication needed by my child and label each item with my child's name. I will submit a *Medication Administration Form* and obtain *Doctor's Orders* for each prescription medication. A new *Medication Administration Form* and *Doctor's Order* is required at the beginning of each school year. _____ **PARENT INITIALS**

I will contact the health office at my child's school if the medication or treatment plan for this allergy changes during the school year. _____ **PARENT INITIALS**

- ☐ Epi-Pen on file in the health office. Expiration: _____
- ☐ Antihistamine on file in the health office. Expiration:_____
- ☐ *Medication Administration Form* is completed. A new form is required at the beginning of each school year.
- ☐ *Doctor's Orders* have been received. A new order is required at the beginning of each school year.

OVER→

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Student is allergic to:	_____ _____
Is student asthmatic?	☐ Yes ☐ No
Does student have inhaler?	☐ Yes ☐ No
Has allergy testing been done?	☐ Yes ☐ No If yes, when?_____
Is student undergoing desensitization?	☐ Yes ☐ No If yes, completion date:_____
What is the usual or past reaction to allergen? (Please check one and circle all symptoms that apply.)	☐ Mild local Reaction: Redness, mild swelling or itching. ☐ Severe Reaction: Redness, hives, itching or rash over a large area, swelling of face or tongue; difficulty swallowing, breathing or talking; weakness and/or dizziness; nausea and/or vomiting; fainting or loss of consciousness.
How soon after exposure does reaction occur?	_____
How should staff respond in the event of a reaction? (Please check all that apply.)	☐ Give antihistamine for mild, local reaction. Call parent/guardian. ☐ Standard District Procedure: For severe symptoms as listed above, give Epi-pen, call 911 and parent/guardian, transport to preferred hospital. ☐ Other treatment:_____ _____ _____

Describe any additional information about your child's allergy that you would like staff to know:

_____

_____

_____

_____