SEVERE ALLERGY SURVEY

Student: _____ Grade: _____ School Year: _____

1. Please indicate what your child is allergic to from the selection below:
   ☐Peanuts ☐Tree Nuts ☐Eggs ☐Dairy ☐Insect Strings ☐Latex
   ☐Fish ☐Soy ☐Other: _____
2. Please indicate when your child reacts to the allergen(s) indicated above:
   ☐Eats it (raw/cooked) ☐Touches it ☐Inhales it
   ☐Other: _____
3. When and how did you become aware of your child's **first** allergic reaction?_____
   _____
4. When was the last time your child had an allergic reaction?_____
5. Please check the type of allergic reaction (signs and symptoms) your child has had in the past.
   ☐ Itching or tingling of throat; swelling of lips/ tongue/ mouth
   ☐ Hives, itchy rash, swelling of the face or extremities
   ☐ Nausea, abdominal cramping, vomiting, diarrhea
   ☐ Tightening of throat, hoarseness, trouble swallowing
   ☐ Shortness of breath, repetitive coughing, wheezing
   ☐ Fainting, paleness, loss of consciousness, turning blue
   ☐ Other: _____
6. Has your child been seen by a doctor for this allergy? ☐YES ☐NO
7. Is your child aware of their allergy? ☐YES ☐NO
8. If your child was seen in an emergency room because of an allergic reaction, what medication(s) were given to your child at that time? _____
   _____
9. Has an EpiPen® been prescribed for your child? ☐YES ☐NO
   Do they know how to use it? ☐YES ☐NO
   Should your child have an EpiPen® at school? ☐YES* ☐NO

   *Food Allergy & Anaphylaxis Emergency Care Plan, School Medication Authorization Form and prescribed medication should be turned in to the school nurse
10. How do you treat your child's allergic reactions at home?_____
    _____
11. Would you like your child to sit at a *Peanut Free/Nut Free* table during lunch? ☐YES ☐NO

_____ _____
SIGNATURE OF PARENT OR PERSON DOING PHONE INTERVIEW *DATE*