EDMONDS SCHOOL DISTRICT NO. 15, EDUCATION HEALTH SERVICES
LYNNWOOD, WA 98036-7400
Educational Health Services

ALLERGIC REACTION FORM

Student Name:	Birthdate:	Date:
School:	Grade:	

DIRECTIONS: Please fill in your student's allergies in the following boxes. Check the severity of reaction and symptoms present. Examples are food allergies, animal allergies, insect allergies (wasps, bees, hornets, fire ants), or latex allergies. You can use one box for a number of allergies if the severity and symptoms are the same. **Please return ASAP**.

Severity of reaction

Allergy to:	**Mild**	**Moderate**	**Severe**	**Symptoms**: **check all that apply**
	☐	☐	☐	☐ itching ☐ hives ☐ eczema ☐ nausea ☐ rash: ☐ tingling ☐ wheezing ☐ difficulty breathing ☐ cramps ☐ dizziness ☐ vomiting ☐ diarrhea ☐ swelling: where: ☐ other:
	☐	☐	☐	☐ itching ☐ hives ☐ eczema ☐ nausea ☐ rash: ☐ tingling ☐ wheezing ☐ difficulty breathing ☐ cramps ☐ dizziness ☐ vomiting ☐ diarrhea ☐ swelling: where: ☐ other:
	☐	☐	☐	☐ itching ☐ hives ☐ eczema ☐ nausea ☐ rash: ☐ tingling ☐ wheezing ☐ difficulty breathing ☐ cramps ☐ dizziness ☐ vomiting ☐ diarrhea ☐ swelling: where: ☐ other:

How many times has your student had a reaction? __________________ When was the last time? ___________________

Are the reactions: ☐ Staying the same ☐ Getting worse ☐ Getting better

How soon did the reaction occur after contact with allergen? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

What was the first symptom, next symptom, etc and time from exposure: ____

____

Did you give medication? ☐ No ☐ Yes: what and how soon after reaction? __________________________________

Did the medication resolve the reaction? ____

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

____

Has your student had allergy testing? ☐ No ☐ Yes: when/where? ____

Has your student had immunotherapy? ☐ No ☐ Yes: when/where? ________________for how long? ______________

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

____

Does your student have an EpiPen? ☐ No ☐ Yes: How many times was it given before symptoms subsided? _________

Has student been instructed in its use? ☐ No ☐ Yes: By whom: ____

Can your student self-monitor his/her allergies competently and independently? ☐ No ☐ Yes

Does your student have a medical alert bracelet? ☐ No: Ask health care provider for information ☐ Yes

Do we have your permission for students in the classroom to know of the allergy? ☐ No ☐ Yes

Is your student involved in **school sponsored** after school activities/sports? ☐ No ☐ Yes: **what?** __________________

*****If so, it is your responsibility to inform coach/advisor of your student's medical condition. If you inform the nurse, the medical alert will be distributed to coach/advisor, if indicated.*****

Does your student take the school bus to school? ☐ Never ☐ Sometimes ☐ Always: If student rides the bus he/she should always sit at the front close to the driver

The Edmond's District's *Food Services do not knowingly serve peanut products to students in grade K-8.*

IF STUDENT HAS A MODERATE- SEVERE ALLERGY, STRICT AVOIDANCE OF FOOD IS THE ONLY WAY TO KEEP THEM SAFE, THUS WE ASK PARENTS TO SEND IN FOOD FOR THEIR CHILD: LUNCH/SNACKS

Does your student follow the "no trade" rule for food and utensils at school? ☐ No ☐ Yes

Will your student ☐ buy lunch: You must review the Allergy Information for Lunch Items on district webpage (www.edmonds.wednet.edu)> Our Departments and Programs> Food Services or ask for copy in office

☐ bring lunch ☐ both

Do you review the lunch menu/website monthly if your student buys lunch? New items are posted in 4 week cycles

☐ No ☐ Yes

Can your student read labels and determine with certainty if the food is allergen free? **(teachers cannot do this)**

☐ Yes ☐ No: **parent to supply teacher with a few special snacks to keep at school**

Teachers cannot determine if homemade treats or packaged foods sent in with students to share in the class are allergen free. We recommend you store a few special snacks for your student at school as we cannot safely offer those treats

We have centralized eating. Does your student require an allergy free area to eat (e.g., No peanut area of table)?

☐ No restrictions on where student eats ☐ Yes: **see below**

- Student sits at end of class's cafeteria table with allergen free area noted by table card that prohibits the allergic food near that the student. Area is wiped especially by adult before and after students eats there. Student's friends can sit by your student but adult checks that they have none of the allergic food before your child eats

If you student has an allergy to eggs: ☐ N/A ☐: Yes:

Can he/she eat eggs in baked goods? ☐ No ☐ Yes

Are there any baked goods or other food products (if OK to eat eggs in baked goods) your student CANNOT have?

☐ No ☐ Yes: Name: _____

Does your student have asthma? ☐ No ☐ Yes: what are triggers? _____

Daily asthma medications? ☐ No ☐ Yes: what meds? _____

Last time used albuterol inhaler _____ How often is inhaler used? _____

Environmental allergies? ☐ No ☐ Yes: what? _____

On ☐ daily or ☐ as needed meds for allergies? ☐ No ☐ Yes: what? _____

Will you supply medication to keep at school (to be stored in office or to carry if appropriate)? ☐ No ☐ Yes

*****If yes, student's doctor must complete an Authorization for Administration of Medication at School form (office)***

List primary care doctor and/or specialists involved in your child's care

Physician	**Type of MD**	**Date last seen**	**Phone Number**

Does your student have health insurance? ☐ *No* ☐ *Yes: what?* _____

Dental insurance? ☐ *No* ☐ *Yes: what?* _____ *Dentist:* _____

List who you want contacted if needed with home/work/cell phones: *Place in order of # you want called 1st, 2nd, etc.*

1. Name:	Relationship:	**Phone numbers**: 1. ( ) / 2. ( ) / 3. ( ) /
2. Name:	Relationship:	**Phone numbers**: 1. ( ) / 2. ( ) / 3. ( ) /

_____ _____ _____

Parent/Guardian Signature/ Relationship **Parent e-mail** **Date**