

Midland School
Allergy Assessment Form

School Year _____

Student's Name _____ Age _____ Grade/Class _____

Please list student's allergies _____

Doctor student sees for allergies _____ Telephone _____

****Should your child sit at the peanut/nut free table in the cafeteria? ___ YES ___ NO**

History/Background Information:

1. At what age was the allergy first diagnosed?
2. Has your child ever had an anaphylactic reaction to the allergen and if yes, what symptoms did he/she have at the time?
3. What are the usual characteristics of your child's allergic reaction, length of time from when allergen contacted until symptoms occur, symptoms your child presents with.
4. Has your child ever been hospitalized for a previous allergy reaction?
5. Date of last allergy reaction:
6. Were there any changes in the severity of the reaction?
7. What are your child's feelings about the diagnosis/impact on lifestyle?
8. Is your child aware of the allergen that triggers his/her allergic reaction?
9. Does he/she know how to avoid these triggers?

Treatment:

1. What medications are prescribed for treating your child's allergic reaction?
2. Are there any additional first aid measures prescribed by your healthcare provider?
3. Has epinephrine ever had to be administered?
4. Has your child been instructed in the use of an epipen?
5. Is he/she capable of administering the epipen to himself/herself?
6. Does your child need special considerations related to his/her allergy while at school?
7. If your child is exposed to the allergen, what actions do you advise school personnel to take?

Please initial and date below, and return to the health office

Initial Date

Initial Date

Initial Date

Initial Date

