Kimberly School District

141 Center Street West Kimberly, Idaho 83341 Phone: 208-423-4170 Fax: 208-423-6155

Allergy Questionnaire

To be completed by parent/guardian

Student Name_____ Date of Birth_____ School Year_____

School_____ Grade_____ Physician_____ Physician Phone_____

To provide care while this child is at school, please complete the information below and return the form to the school or district offices.

Has this child been diagnosed with allergies/anaphylactic reactions by a healthcare provider? ☐ Yes ☐ No

Please list all of the child's allergies, including foods:

If this child has food allergies, does your child bring lunch from home? ☐ Yes ☐ No ☐ N/A
If no, then a Medical Statement form must be on file from their medical provider.

Does this child react to skin contact with the allergen? ☐ Yes ☐ No
If so, what is the reaction?

Does this child react to swallowing the allergen? ☐ Yes ☐ No
If so, what is the reaction?

How soon after exposure does this child react?

How does this child prevent and respond to an allergic reaction? (check all that apply)

- ☐ The child knows what to avoid
- ☐ The child asks about ingredients in food, if unsure
- ☐ The child tells others about his/her allergies
- ☐ The child will **immediately** tell an adult if exposed to an allergen
- ☐ The child can give their own injection with an epinephrine auto-injector if prescribed by their physician.
- ☐ Other_____

What medical care was given in the past? (fill out all that apply)

- ☐ Cold compress (in cases of a sting)
- ☐ Oral medication: What was used? _____
- ☐ Injection: What was used? _____
- ☐ Treatment in doctor's office _____
- ☐ Treatment in the Emergency Room or your child was in the hospital?_____
- ☐ Other _____

Does this child wear an identifying tag or bracelet alerting others to the allergy? ☐ Yes ☐ No

Are medications required to be kept at school? ☐ Yes ☐ No **If yes, what kind?** _____

_____

(*All medications at school require the Medication Authorization to be on file*)

Any other information that would be helpful to know? _____

I authorize Kimberly School District to communicate with the student's healthcare providers, teachers and other appropriate school staff about the allergies.

Parent/Guardian Signature _____ **Phone** _____ **Date** _____
School Nurse _____ **Date** _____