



North Santiam School District

SEVERE ALLERGY 2023-24

Student name: _____ Date of birth: _____

Grade: _____ School: _____

<p>What is your child severely allergic to?</p>	<p>What symptoms has your child experienced?</p> <p><input type="checkbox"/> Facial swelling <input type="checkbox"/> Throat swelling <input type="checkbox"/> Hives or rash</p> <p><input type="checkbox"/> Difficulty breathing or swallowing <input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Burning sensation <input type="checkbox"/> Changes in skin color</p> <p><input type="checkbox"/> Sneezing/wheezing/coughing <input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Nausea/ vomiting/ diarrhea <input type="checkbox"/> Other (describe below):</p> <p>_____</p>
<p>When was your child's first severe allergic reaction?</p>	<p>Has your child needed emergency treatment or had to be hospitalized because of a severe allergic reaction?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> If yes when?</p>
<p>When was your child's last severe allergic reaction?</p>	<p>How has the reaction been treated in the past? (Medication name(s), dose and frequency)</p>
<p>How does your child's reaction occur?</p> <p><input type="checkbox"/> Contact <input type="checkbox"/> Inhalation <input type="checkbox"/> Ingestion <input type="checkbox"/> Sting</p>	<p>Does your child also have <i>asthma</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what is used to control your child's asthma?</p>
<p>Does your child have emergency medications prescribed to treat their severe allergy? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List of medications taken on a daily or routine basis (include name, dose and frequency):</p>
<p>If yes, which device does your child currently have:</p> <p><input type="checkbox"/> Amneal (0.15 mg) <input type="checkbox"/> Amneal (0.3 mg)</p> <p><input type="checkbox"/> Auvi-Q (0.15 mg) <input type="checkbox"/> Auvi-Q (0.3 mg)</p> <p><input type="checkbox"/> EpiPen Jr (0.15 mg) <input type="checkbox"/> EpiPen (0.3 mg)</p> <p><input type="checkbox"/> Teva (0.15 mg) <input type="checkbox"/> Teva (0.3 mg)</p>	<p>Is there anything else that is important to know about your child's health?</p>
<p>Who is currently treating your child's allergies? (Name and phone number)</p>	

Parent signature: _____ Date: _____