

Coatesville Area School District Parent/Guardian Questionnaire for Students with Severe Allergies

Student Name _____ School: _____

School Year: _____ Grade _____ Date _____

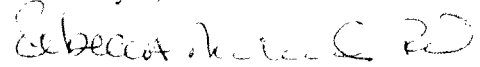
Dear Parent/Guardian,

You noted on the emergency card that your child is allergic to _____. In order to give the appropriate care, we request that you complete this form and return it to the school nurse immediately.

We have Benadryl in the health office, however if your child needs adrenaline for his/her reaction please send in an Epi-Pen to be left in school.

If there is any change in this information during the school year, please notify the school nurse in writing.

Thank you,



School Nurse

Symptoms student has experienced in the past. (please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Swelling/redness in sting area | <input type="checkbox"/> Swelling of lips, tongue, throat |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Breathing difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Thickened speech |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Extreme weakness |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blue color of skin or lips |
| <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Skin flushed all over the body |
| <input type="checkbox"/> Itching all over the body | <input type="checkbox"/> Other _____ |

Medications needed:

Name _____

Dose _____ Time: _____

Special Instructions _____

Name of Physician _____ Phone Number _____

I understand the above information will be used in an emergency action plan for my child. I give my permission to share this plan with my child's assigned teachers and appropriate personnel.

Signature of Parent/Guardian _____ Date _____