

# PITTSFORD CENTRAL SCHOOL DISTRICT

## Parent Interview Questionnaire for Individualized Health Plan

### ANAPHYLAXIS – SEVERE ALLERGIC REACTION

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_  
 Teacher \_\_\_\_\_ Information provided by \_\_\_\_\_ Date \_\_\_\_\_

Please answer all questions. Use the back of this form for explanation or any additional information you feel important for us to know.

Who does your child see for regular health visits? \_\_\_\_\_ Phone \_\_\_\_\_

Who does your child see for allergy management? \_\_\_\_\_ Phone \_\_\_\_\_

Your child has been diagnosed with a severe allergy to: \_\_\_\_\_

When was your child diagnosed with this allergy? \_\_\_\_\_ at age \_\_\_\_\_

Has your child been diagnosed with any other medical conditions?

No  Yes (explain) \_\_\_\_\_

How many times has your child had a severe reaction? \_\_\_\_\_ Date of last episode \_\_\_\_\_

What symptoms does your child experience during an allergic reaction? \_\_\_\_\_

How would your child describe his/her symptoms when experiencing a possible allergic reaction? \_\_\_\_\_

What triggers cause your child to experience mild to severe allergy symptoms? \_\_\_\_\_

Has your child been to the emergency room or hospitalized due to this allergy/reaction?

No  Yes (explain) \_\_\_\_\_

Have any **emergency medications** been prescribed for your child?

Antihistamine  No  Yes      Epinephrine  No  Yes

Name of Medication	Amount	When Taken

Has your child been instructed on when and how to take these medications independently?  No  Yes

Is your child participating in sports or school sponsored extracurricular activities?  No  Yes

Does your child carry emergency medications in school and at these activities?  No  Yes

Is your child able to recognize early signs/symptoms of an allergic reaction?  No  Yes

Is your child comfortable alerting others when experiencing possible allergic symptoms?  No  Yes

What are your child's feeling/fears regarding his/her allergy? \_\_\_\_\_

Does your child wear a "**medic alert**" bracelet/necklace?  No  Yes

Do you feel your child's understanding of his/her allergy is?

very good  good  fair  limited

Has your physician indicated **in writing** that your child needs any special accommodations in school?

No  Yes (explain) \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Pittsford Central School District

## EMERGENCY CARE PLAN: ALLERGY/ANAPHYLAXIS

### To be completed by Parent

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher/HR: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Asthmatic:  yes\*  no \*increased risk for severe reaction Insurance: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

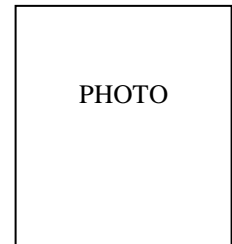
I give permission to share this plan with physician and school staff. I agree with the physician's orders as outlined below.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SYMPTOMS AND SIGNS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

(highlighted indicates previous response by the student)

- **MOUTH** itching and swelling of the lips, tongue, or mouth
- **THROAT** itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- **SKIN** hives, itchy rash, and/or swelling about the face or extremities
- **GUT** nausea, abdominal cramps, vomiting and/or diarrhea
- **LUNG** shortness of breath, repetitive coughing and/or wheezing
- **HEART** "thready" pulse, "passing-out"



**The severity of the symptoms can quickly change. It is important that treatment is given immediately.**

### To be completed by Physician

Allergens (Please List) \_\_\_\_\_

#### ACTION:

For suspected exposure/ingestion, IMMEDIATELY administer:

**Benadryl** (\_\_\_\_\_)  **Epi Pen Junior**  **Epi Pen**  **Other** \_\_\_\_\_  
dose in mg (please print)

If the following symptom(s) develop: \_\_\_\_\_ IMMEDIATELY administer:

**Benadryl** (\_\_\_\_\_)  **Epi Pen Junior**  **Epi Pen**  **Other** \_\_\_\_\_  
dose in mg (please print)

I give permission for this student to **self-carry** and **self-administer** the above medication(s).  **YES**  **NO**

If so, s/he has been instructed in and understands the purpose and appropriate method and frequency of administration of the above medication(s).

Doctor Name (Please Print): \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Information for Staff:

If symptoms or suspected exposure occur, follow plan, then contact school nurse at \_\_\_\_\_ and parent. For bee stings, remove stinger if visible and apply ice to the area.

If Epi-Pen/Epi-Pen Jr. is administered, call 911. It provides a 20 minute response window. The student may experience an increased heart rate. This is normal. A staff member should accompany student to ER if the parent/emergency contact cannot be reached.

This plan is in effect for the current school year.

Please return to \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_