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"

PHOTO

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 # _____