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: ___________________________ at age ________

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

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<th>Name of Medication</th>
<th>Amount</th>
<th>When Taken</th>
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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: __________

________________________________________________________________
________________________________________________________________
________________________________________________________________

Anaphylaxis Questionnaire / 8/02
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 # ________________

Anaphylaxis Questionnaire / 8/02