PITTSFORD CENTRAL SCHOOL DISTRICT
Parent Interview Questionnaire for Individualized Health Plan
LATEX ALLERGY

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 ______
When was your child diagnosed with a latex allergy? ___________________________ at age ______
Has your child been diagnosed with any other medical conditions?
☐ No   ☐ Yes (explain) ______
What symptoms does your child experience when exposed to latex? ______

How would your child describe these symptoms? ___________________________

Can these symptoms occur without direct contact? ___________________________
Which latex product(s) cause a reaction? ___________________________
When was your child’s last allergic reaction to latex? ___________________________
Has your child gone to the emergency room or been hospitalized due to his/her latex allergy?
☐ No   ☐ Yes (explain) ___________________________

What medications does your child take to manage his/her allergy symptoms?

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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 medication in school and at these activities?
☐ No   ☐ Yes
What are your child’s feelings about having a latex allergy? ______

Is your child comfortable alerting others when experiencing possible allergic symptoms?
☐ No   ☐ Yes
What products does your child know to avoid due to his/her allergy? ______

Does your child wear a “medic alert” necklace/bracelet? ☐ No   ☐ Yes
Do you feel your child’s understanding of his/her latex 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: ________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Latex 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 # ___________

Latex Questionnaire / 8/02