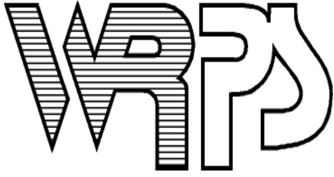


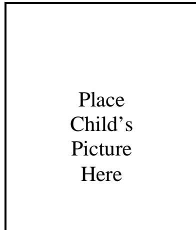
SEVERE ALLERGY QUESTIONNAIRE

WISCONSIN
RAPIDS
PUBLIC
SCHOOLS

Student Name: ______________________________________ D.O.B. _________ Teacher: _________________________

Allergy to: ____

Asthmatic _____ YES* _____ NO *High risk for severe reaction



Place Child's Picture Here

If your child's anaphylactic bee sting allergy reaction is resolved and is no longer a medical concern, check on the line, sign and return the form to school.

_________My child's anaphylactic bee sting allergy is resolved.

PARENT SIGNATURE: ____________________________________ **DATE:** __________________________

SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms
Mouth	Itching &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 symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

ANPHYLACTIC ALLERGY ACTION PLAN
Follow these steps if my child has a reaction at school. Check all boxes that apply to your child's care.

1. If my child has been exposed to the allergen at school, staff will:

   Give Benadryl
   - ☐ Dose:_______________________
   - ☐ Immediately after being exposed.

   Give EPI-PEN to my child – CHECK one option
   - ☐ Immediately after being exposed.
   - ☐ When symptoms appear.

2. Staff will call 911 WHEN the EPI-PEN is given. EMT's will take your child to the nearest local hospital emergency room for more care.

3.Transportation Plan: ☐ Medication available on bus ☐ Medication NOT available on bus ☐ Does not ride bus

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4. Co-Curricular Plan:

☐ Student will manage ☐ Advisor/Supervisor will manage (additional supply will be necessary)

List of activities:

5. School Day Storage Plan (High School Only):

☐ Health Office ☐ Locker ☐ Self

Memo of Understanding

1. It is understood that the parent will complete and sign this form annually.
2. It is understood that the parent will provide the emergency medications needed at school and sign the Parent/Physician Medication Consent Form.
3. It is the responsibility of the parent to notify the district nurse of changes in health plan.
9. It is the responsibility of the parent to notify the bus company.

PARENT PERMISSION

I verify that the above information is correct. I give my permission to share this information with staff on a need to know basis.

The information is **valid for ONE school year**. **Annual parent signature is required**.

Parent/guardian signature: ____________________________________ Date: ____________________

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