Lawrence Public Schools- Severe Allergy History and Intake Form

Student's Name: _____ DOB: ____/_____/_____ Grade: _____

Name of physician treating student's allergies: _____ Phone: _____

Parent/Guardian: _____ Contact Information: _____

Emergency Contact: _____ Contact Information: _____

History and Current Status:

Does your child have a history of asthma? ☐ Yes ☐ No

Allergy has been confirmed by**:** ☐RAST testing ☐Skin testing ☐ Physician diagnosis

Student is allergic to (check all that apply):

☐ Peanuts ☐ Tree Nuts ☐ Eggs☐ Milk/Dairy ☐Fish/Shellfish☐ Soy
☐ Wheat ☐ Insect Stings ☐ Latex ☐Chemical ☐Other: _____

Age/date of when allergy was first discovered: _____

How many times has student had a reaction? ☐Never ☐Once ☐More than once, explain: _____

_____

Explain past reaction(s) and symptoms: _____

Trigger and Symptoms:

What are student's early signs and symptoms of an allergic reaction? _____

_____

How quickly do symptoms appear after exposure? _____

How does student communicate symptoms/what might your student say during a reaction? _____

_____

Please check *all* symptoms that student has experienced in the past:

Skin: ☐Itching ☐ Hives/Rash ☐Flushing ☐Swelling (face/arms/hands/legs)
Mouth/Throat: ☐Itching ☐ Tightness ☐Hoarseness ☐ Swelling (throat/lips/tongue)
Abdominal: ☐Nausea ☐ Vomiting ☐Diarrhea ☐Abdominal pain/Cramps
Lungs: ☐Wheezing ☐Repetitive cough ☐ Difficulty breathing/Shortness of breath
Heart: ☐ Weak pulse ☐Loss of consciousness
Other:_____

Treatment:

What treatment or medication has your healthcare provider recommended/prescribed for use in an allergic reaction? _____

How have past reactions been treated? _____

Has an epinephrine (such as Epi Pen) injection been given for a past reaction? ☐Yes ☐No

School Treatment Plan:

Lawrence Public Schools- Severe Allergy History and Intake Form

Will you provide medications to be kept at school? ☐Yes ☐No
What medications: ☐Epinephrine (medication/dose/route): _____
☐antihistamine(medication/dose/route): _____
Where will the meds be kept? ☐Student will self-carry (complete self-administer medication form)
☐ Health Office (complete medication administration form)

Treatment of symptoms:

Mouth/Throat: itching, tightness, hoarseness, cough, swelling(lips/tongue/mouth)	☐ antihistamine ☐ EpiPen
Skin: Hives/rash, itching, flushing, swelling (face/arms/hands legs)	☐ antihistamine ☐ EpiPen
Abdominal: Nausea, vomiting, diarrhea, abdominal cramps	☐ antihistamine ☐ EpiPen
Lungs: Difficulty breathing, shortness of breath, wheezing, repetitive cough	☐ antihistamine ☐ EpiPen
Heart: weak pulse, loss of consciousness, fainting, pale	☐ antihistamine ☐ EpiPen
General: Panic, sudden fatigue, chills, fear of impending doom	☐ antihistamine ☐ EpiPen
If a food allergen has been ingested, but no symptoms:	☐ antihistamine ☐ EpiPen
If a reaction is progressing (several of the above areas affected):	☐ antihistamine ☐ EpiPen

<u>For Food Allergies</u>

Classroom snacks/treats from other students:
Lawrence Public Schools highly recommends that parents/guardians provide elementary-age students with known food allergies a supply of individualized snacks and/or treats.
____I will provide ***all*** of my child's snacks/treats. He/she/they is not to eat other snacks/treats at school.
____ I will ***not*** provide my child's snacks/treats. I understand that school district employees will **NOT** be responsible for reading ingredient labels of snacks/treats or inquiring what ingredients were used in homemade snacks/treats.

Lunchroom Seating- An option for young students with severe peanut/nut allergy is to sit at a designated peanut/nut free only table.

____ My child should sit at a "peanut/nut/allergen free" table
____ My child does NOT need to sit at a "peanut/nut/allergen free" table

The Lawrence School District recommends this questionnaire as a tool to help prepare an Individualized Health Care Plan for the student, **not as a guarantee** that contact with the offending substance will be avoided. If an allergic reaction occurs at school, we will notify you in addition to giving any parent or physician ordered medications. We encourage all students with identified severe allergies to have emergency medication available at school through a required physician order.

Parent/Guardian Signature: _____ Date:_____