Parent/Guardian Questionnaire for Students with Severe Allergies
Coatesville Area School District

In order to give the appropriate care, we request that you complete this form and return it to the School Nurse. Please inform the School Nurse in writing if there are any changes during the school year.

Student Name____School:____________________________

School Year: ___________________ Grade __________ Homeroom/Advisory _______________

My child is allergic to____

Symptoms student has experienced in the past. (please check all that apply)

___Swelling/redness with skin contact area

___Hives

___Hoarseness

___Dizziness

___Nausea

___Vomiting

___Abdominal cramps

___Itching all over the body

___Swelling of lips, tongue, throat

___Wheezing

___Breathing difficulty

___Thickened speech

___Extreme weakness

___Blue color of skin or lips

___Skin flushed all over the body

___Other____________________________

Medications needed:

Name _______________________________________ Dose/Frequency____________________________

Name _______________________________________ Dose/Frequency____________________________

Special Instructions____

Can student use his/her Epipen/Inhaler (if needed) without help? ______ YES ______ NO

****PLEASE REFER TO MEDICATION POLICY/PERMISSION FORM IF MEDICATION IS NEEDED AT SCHOOL****

Name of Physician ________________________________ Phone Number _____________________________

I understand the above information will be used in an emergency action plan for my child. I give my permission to share this plan with my child's assigned teachers and appropriate personnel.

Signature of Parent/Guardian____ Date_______________