DARBONNE WOODS CHARTER SCHOOL

Allergic Response Questionnaire

To better help us care for your child at school, please complete the following questions.

Students Name _____ DOB _____

1. Please check off any and all foods or insects your child is allergic to:

A. **FOODS**

_____nuts _____fruit _____wheat _____milk __other _____

By: □touch □smell/breathing □eating

B. **SEAFOOD**

_____crabs _____shrimp _____crawfish _____fish __other _____

By: □touch □smell/breathing □eating

C. **INSECTS**

_____fire ants _____wasp _____honey bee _____spider __other _____

2. If your child is allergic to nuts, does this include all forms, such as oils, peanut butter, etc.

yes_____ no_____ If yes list _____

3. Please describe your child's reaction to the food or insect:

A. How soon after eating, touching or being stung did the reaction occur?

seconds_____ minutes_____ hours_____ days_____

B. Has your child ever been seen in the emergency room for an allergic reaction?

yes_____ no_____ If yes, when? _____

C. What type of allergic reaction did your child experience? Check all that apply.

__itching __red rash __hives __localized swelling __vomiting __nausea

__wheezing __difficulty breathing __loss of consciousness __tightening in throat

__any other reactions _____

4. Is your child or any medication at home due to his/her allergy?

yes_____ no_____ If yes, list _____

5. Will your child receive any medications at school due to his/her allergy?

Epi Pen Jr._____ Benadryl_____ Claritin_____ Other _____

6. Will your child require a special diet prescribed by doctor at school? ___yes ___no

7. Does child ride the school bus? ___yes __no Bus # _____ Driver's Name _____

_____ _____

Parent/ Guardian Signature Date