SUMTER COUNTY SCHOOLS - SCHOOL HEALTH SERVICES

ALLERGY PARENT INTERVIEW GUIDE

Please complete this form with as much accurate information as possible. The information provided is used to develop an individualized health care plan for your child to promote a safe environment with a goal to maintain optimal health. Important: Include correct numbers where you can be reached.

Student's Name: _____ Date of Birth: _____

Student's Address: _____

Age: _____ Grade: _____ Teacher: _____ School: _____

Parent/Guardian: _____ Phone #1: _____

_____ Phone #2: _____

Emergency Contacts: _____ Phone #1: _____

_____ Phone #2: _____

Prescribing Doctor: _____ Phone: _____

Fax: _____

Preferred Hospital: _____

1.Medical diagnosis: _____

Severity (Please circle one): MILD MODERATE SEVERE

2. What is your child allergic to? _____

3. Which type of contact does reaction occur with? *(Check all that apply)*

☐ Ingestion ☐ Skin Contact ☐ Inhalation ☐ Sting ☐ Bite

4. What are his/her usual signs of a problem? *(Check all that apply)*

☐ Itching ☐ Cough ☐ Swelling ☐ Hives ☐ Flushed Skin ☐ Wheezing

☐ Passing Out ☐ Nausea ☐ Vomiting ☐ Anxiety ☐ Confusion ☐ Difficulty Breathing

☐ Rapid Heartrate ☐ Abdominal Pain ☐ Other: _____

5. Does your child have asthma? _____

6. Does your child know what precautions to take to avoid allergens? _____

If this is a food allergy: will your child be bringing all his/her own food to school? _____

7. What type of medications (include all for home and school) does your child take and when?

_____

8. Is there an Epinephrine Auto Injector prescribed? _____ *(If no, skip to question 9)*

Has your child been trained by a licensed practitioner to use the Auto Injector? _____

Is your child able to use and know when to use the Auto Injector to self-inject? _____

Will he/she be carrying his/her own Auto Injector at school? _____

If yes, how is your child transported to school? _____ If by school bus, what route? _____

9. Any special instructions? _____

_____

As parent/guardian by signing this form, I give permission for Sumter County Schools to share this information with the faculty and staff who are directly involved in my child's education and/or school health services.

_____ _____ _____

Parent signature Please Print name Date