

**ST. MARY'S COUNTY PUBLIC SCHOOLS**  
*Department of Student Services/ St. Mary's County Health Department*

**FOOD ALLERGY INFORMATION**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Diagnosed by Doctor:  Yes  No Doctor's Name: \_\_\_\_\_

Date of Last Allergic Reaction: \_\_\_\_\_

1. Do you consider the food allergy to be life threatening to your child?  Yes  No

**If Yes, a Food Allergy Emergency Action Plan may be needed at school.**

2. Please list any daily or as needed medications your child takes.

	Name of Medication	Dose	Frequency
<b>(In School)</b>	_____		
	_____		

**If medication is needed at school, please have your doctor complete a Medication Authorization form.**

**(At Home)** \_\_\_\_\_

3. Does your child have a prescribed EpiPen for emergency use?  Yes  No

4. Please check the type of food allergy:

- |  |  |
|--|--|
| <input type="checkbox"/> peanuts and peanut products     | <input type="checkbox"/> fish                    |
| <input type="checkbox"/> tree nuts: (fill in kind) _____ | <input type="checkbox"/> crustacean (shell fish) |
| <input type="checkbox"/> eggs                            | <input type="checkbox"/> corn                    |
| <input type="checkbox"/> cow's milk products             | <input type="checkbox"/> other _____             |
| <input type="checkbox"/> soybeans and soy formula        |  |
| <input type="checkbox"/> wheat                           |  |

5. Please check only those symptoms which you have observed when your child has had an allergic food reaction:

- |  |  |
|--|--|
| <input type="checkbox"/> itching or swelling of lips, tongue, or mouth   | <input type="checkbox"/> swelling about the face or extremities                          |
| <input type="checkbox"/> nasal congestion                                | <input type="checkbox"/> difficulty breathing, shortness of breath or wheezing           |
| <input type="checkbox"/> runny nose, sneezing, or sniffing               | <input type="checkbox"/> difficulty swallowing or choking                                |
| <input type="checkbox"/> itching or sense of tightness in the throat     | <input type="checkbox"/> repetitive coughing   |
| <input type="checkbox"/> sore throat or throat clearing, "hacking" cough | <input type="checkbox"/> dizziness or fainting   |
| <input type="checkbox"/> hoarseness                                      | <input type="checkbox"/> shock (fall in blood pressure and increased thready pulse rate) |
| <input type="checkbox"/> nausea or vomiting                              | <input type="checkbox"/> unconsciousness   |
| <input type="checkbox"/> abdominal cramps or diarrhea                    | <input type="checkbox"/> other _____   |
| <input type="checkbox"/> hives   |  |

6. Progression of symptoms were: (Please check.)

- increasing and worsening rapidly  
 early, mild symptoms with apparent resolution followed by rapid development of lung and/or heart symptoms  
 other \_\_\_\_\_

7. How long after being exposed to the allergen did your child develop symptoms? (Please check.)

- immediately  
 within 15 – 20 minutes  
 within an hour  
 longer than one hour (specify time) \_\_\_\_\_

8. Has your child ever been hospitalized (emergency room) for an allergic reaction?

Yes  No

9. Does your child know to avoid the allergen?  Yes  No

10. If your child has a nut allergy, do they need to sit at the nut-free table during lunch?  Yes  No

Parents'/Legal Guardians' Signature \_\_\_\_\_

Date \_\_\_\_\_