PITTSVILLE PUBLIC SCHOOLS

_______ School Year

Allergy Questionnaire

In reviewing your student's Emergency Notification Form, it was noted that they have an allergy to food, medication, bee/insect stings, latex, or other allergen. In order for school personnel to deal with the problem in the most effective way please provide the following and return to school.

Name of student ____

Allergic to: ____
Name of food, peanut, type of nut, medication, bee/insect, latex, or other allergen

What symptoms does your student usually have? (Please be specific)

____

____

____

If the student is exposed to the above listed allergen during school hours, the following procedure is recommended by the parent and the student's physician:

______Watch for symptoms and contact parents

______Immediately administer medication as directed on medication form

______call rescue unit**

______other ____

____

**A rescue unit will be called in all situations where a student is experiencing potentially life threatening symptoms or a prescription epi-pen has been administered.

Please discuss your decision with your child so that they understand what action should be taken. School policy requires a Parent/Guardian Consent Form for Medication to be completed on all students needing medication at school. In addition, if the medication is a prescription medication, the Clinician's Order for Administration of Prescription Medication must also be completed and signed by the clinician. Please complete the attached medication form if indicated and send medication to school appropriately labeled.

______________________________ ______________________

Signature of Parent/Guardian Date

AllergyQuestionnaire.doc
10/2007

Appendix 9

PITTSVILLE ELEMENTARY SCHOOL

_______ School Year

Emergency Action Plan
For Student Identified with Allergies

Student Name: ________________________________ DOB: ___/__/___ Grade: ___ Class: ____________
Parent: ____________________________________ Home phone: ____________ Cell # _____________
Clinician ______________________________ Clinic __________________ Clinic Phone: ____________

Diagnosis or Condition: ____

IF YOU SEE THIS: **DO THIS:**

Parent Signature: ____ Date: ___/___/___

School Nurse Consultant: ____ Date: ___/___/___

EAP.doc
2007