OUR LADY OF THE WAYSIDE SCHOOL
432 South Mitchell Avenue • Arlington Heights, Illinois 60005-1894 • T: (847) 255-0050 • F: (847) 253-0543
www.olwschool.org

Annual Severe Allergy Survey – Parent Information **SCHOOL YEAR**_____

Please return this form to the school office by Friday, August 18th. If you prefer, scan/email to schoolnurse@olwschool.org.

Please provide us with information about your child's allergies. Annually, please update this form with new information. If there are questions, your school nurse will follow up with you.

Student Name_____ Grade_____

1. Please indicate what your child is allergic to by checking the appropriate box.

   ____ peanuts ____ bee sting
   ____ tree nuts ____ latex
   ____ milk ____ other _____

2. At what age did your child experience their first allergic reaction? _____

3. Please describe the signs and symptoms of the allergic reaction he/she has had in the past?
   ____ itching, tingling, or swelling of lips, tongue, mouth
   ____ hives, itchy rash, swelling of the face or extremities
   ____ nausea, abdominal cramps, vomiting, diarrhea
   ____ tightening of throat, hoarseness, hacking cough
   ____ shortness of breath, repetitive coughing, wheezing
   ____ fainting, pale, blueness
   ____ other_____

4. Has your child seen a doctor for this allergy?

   ____ Yes ____ No

   If yes, what medical treatment was provided and by whom?

   _____

   _____

5. Has your child been seen at an emergency room because of an allergic reaction, and if so, what medication was given?

6. When was the last time your child had an allergic reaction?

7. How do you treat allergic reactions at home?

8. Does your child have an epinephrine auto-injector at home?

   ____ Yes ____ No

9. If yes, does your child know how to use the epinephrine auto-injector?

   ____ Yes ____ No

10. Please indicate when your child reacts to the allergen by checking the appropriate box

    ____ eats it ____ inhales it

    ____ touches it ____ other_____

11. May we share your child's allergy information with his/her classmates?

    ____ Yes ____ No

12. Does your child need a special seating area at lunch or snack?

    ____ Yes ____ No

13. Parent would like to be offered the option to accompany child on field trips?

    ____ Yes ____ No

Please list other accommodations needed at school:

_____

Parent Signature_____**Date**_____