**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.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(At Home) __________________________________________________________

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

4. Please check the type of food allergy:
   - □ peanuts and peanut products
   - □ tree nuts: (fill in kind) ____________________________
   - □ eggs
   - □ cow’s milk products
   - □ soybeans and soy formula
   - □ wheat
   - □ fish
   - □ crustacean (shell fish)
   - □ corn
   - □ other

5. Please check only those symptoms which you have observed when your child has had an allergic food reaction:
   - □ itching or swelling of lips, tongue, or mouth
   - □ nasal congestion
   - □ runny nose, sneezing, or sniffling
   - □ itching or sense of tightness in the throat
   - □ sore throat or throat clearing, “hacking” cough
   - □ hoarseness
   - □ nausea or vomiting
   - □ abdominal cramps or diarrhea
   - □ hives
   - □ swelling about the face or extremities
   - □ difficulty breathing, shortness of breath or wheezing
   - □ difficulty swallowing or choking
   - □ repetitive coughing
   - □ dizziness or fainting
   - □ shock (fall in blood pressure and increased thready pulse rate)
   - □ unconsciousness
   - □ other ________________________________________________

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** ____________________________

PS 427 – 07/2011 – Food Allergy Information