INTERNATIONAL SCHOOL OF LATVIA

*** If your child has ALLERGIES, please complete this form with the assistance of your child's doctor.*

ALLERGY QUESTIONNAIRE

Child's Name: _____

1. My child has ALLERGIES to : (*circle all that apply)*
   a. certain foods: peanuts, tree nuts, milk, eggs, soy, wheat, fish/shellfish, chocolate, honey, and/or _____
   b. insect bites: bees, wasps, or _____
   c. seasonal pollens: grass, tree, or _____
   d. animal hairs: cats, dogs, or _____
   e. medications: penicillin, aspirin, ibuprofen, paracetamol, or _____
   f. latex
   g. other _____

2. Describe your child's allergic reaction:
   [ ] **mild:** runny nose, itchy/red eyes, frequent sneezing
   [ ] **moderate:** hives, intense itching, "scratchiness" to throat
   [ ] **severe:** difficulty breathing, wheezing, throat tightness, lip swelling; ***high risk for anaphylactic shock***
   [ ] may trigger an asthma attack.

3. Has your child ever had an anaphylactic reaction? [ ] Yes [ ] No
   If YES, when: _____

4. Does your child take medication for this allergy?
   [ ] daily [ ] only as needed [ ] no medications needed

   Please list medications:

Name of Medication	Dosage	Frequency	As needed for	Used at home, school, or both
Ex: Zyrtec tablets	*10mg*	*1 tab daily*	*Seasonal allergies*	*At home only*

5. Is there a need to keep medication at school for this allergy? [ ] Yes [ ] No
   If YES, please fill out an *Authorization to Administer Medication* Form in the Nurse's Office
   If YES, where would you like child's medications to be kept?
   [ ] in the Nurse's Office [ ] in classroom [ ] in child's backpack

6. Does your child have an EpiPen (self-administered injection of epinephrine)? [ ] Yes [ ] No
   If YES, where would you like child's medications to be kept?
   [ ] in the Nurse's Office [ ] in classroom [ ] in child's backpack

7. Are there any limitations/restrictions of physical activities at school due to allergies?
   If yes, please specify _____

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ALLERGY ACTION PLAN

IF WE SEE THIS…	WE WILL DO THIS….
MILD REACTION: Runny nose, itchy eyes, red/puffy eyes, frequent sneezing	1. Give the following medication: Medicine:_____ Dose: _____ Medicine _____ Dose: _____ 2. Observe student closely for any change in condition. 3. Allow student to return to class or normal activity if symptoms are relieved after using medication.
MODERATE REACTION: hives, intense itching, scratchiness to throat, tingling sensation	1. Give the following fast-acting antihistamine: Benadryl liquid 12.5mg/5ml (based on weight) 2. Observe student closely for any change in condition. 3. Allow student to return to class or normal activity if symptoms are relieved after using medication.
No change in symptoms within 5 minutes of using medication(s).	1. Repeat medication above. 2. Observe student closely for any change in condition. 3. Allow student to return to class or normal activity if symptoms are relieved after using medication. 4. No relief after 2 doses, call parents.
SEVERE REACTION or symptoms worsen: difficulty breathing, unable to speak, wheezing, throat tightness, swollen lips, blue lips	1. Administer EpiPen (life-saving injection of epinephrine) 2. Call ambulance and parents. 3. Remain with student until EMS personnel arrive.
Student becomes unconscious	1. Start CPR. 2. Call ambulance and parents. 3. Remain with student until EMS personnel arrive.

- I authorize school personnel to implement this management and emergency plan as described above.
- I give permission for my child to be transported by ambulance in the event of a severe allergic reaction, as described above.

Parent's Signature: _____ Date: _____

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