# West Milford Township Public Schools

Individual Health Care Plan for Student with Food Allergies

Parent Questionnaire
Student's Name: _____Grade: _____
School: _____ Birthday: _____
Classroom Teacher: _____

Parent/Guardian: _____
Address: _____
Home Telephone _____Cell _____Work _____

Email address: _____

**Allergy History:**
Allergens: Please circle one:
*_____Ingestion/Touch/Airborne
*_____Ingestion/Touch/Airborne
*_____Ingestion/Touch/Airborne
*_____Ingestion/Touch/Airborne

**History of Asthma:**

Does your child have asthma? Yes____ No____

If yes, is daily medication taken?
Name and dosage of medication_____

Does your child use an inhaler? Yes____ No____
If yes, how often?
Daily____ Occasionally____ Seasonally____ Other____
Other comments: _____

Would you like an inhaler to be kept in the health office? Yes____ No____

Is your child aware of the signs and symptoms when he/she needs to use an inhaler?
Yes____No____Comments:_____

When was your child's first reaction to a food allergen? Year_____ Age_____

Please provide any information regarding your child's specific signs of an allergic reaction:

**History of Anaphylactic Reactions:**

Has your child ever received epinephrine? Yes____ No____

Have you or anyone else ever had to use an Epipen auto-injector? Yes____ No____
If yes, please explain the circumstances:

**Tell Us about your child:**

Is your child aware of foods that he/she may not eat? Yes____ No____

Is your child aware of the dangers if he/she ingests an allergen? Yes____ No____

If uncertain of a food, would your child be likely to:
(Circle one)

- Definitely refuse it
- Ask an adult if it is ok to eat it
- Eat it, if it looked ok
- Eat it, no matter how it looked

Does your child know how to read food labels for ingredients? Yes____ No____

Is your child aware of the signs and symptoms of exposure to an allergen? Yes____ No____

If your child was not feeling well, would he/she seek help? Yes____ No____
If not, please comment:

Has your child been instructed how to administer his/her Epinephrine auto-injector?
Yes____ No____
If yes, would your child be able to administer in an emergency situation? Yes____ No____

On a scale of 1-5 (5 being highly informed), how would you rate your child's knowledge of his/her food allergy? _____

Is there any other information that you feel would be helpful for us to know about your child?

Parent's Signature: _____
Date: _____

6/09