Seekonk Public Schools

School Health Department

Student Name____

Physician Questionnaire

In an effort to provide optimum health care for ___________________________, we would like to request information relevant to your patient's allergy to ______________________.

1. What type of a reaction has this child had in the past? Please check the most appropriate response.

________ No reaction, but there is a family history of severe allergy.

________ Mild (few hives, itching or swelling at the site of the bite or sting)

________ Severe (Anaphylaxis). How did the symptoms present? Please indicate mild, moderate or severe.

_____Mild (hives, a sensation of fullness of the mouth and throat, swelling of eyelids and lips, sneezing, coughing, nasal congestion, nausea, vomiting, abdominal pain and diarrhea)

_____Moderate (worsening of hives and itching, swelling, flushing, wheezing)

_____Severe (severe swelling of upper airway, difficulty breathing or swallowing, shock, loss of consciousness)

2. If the allergen was a food, what triggered the allergy attack?

_____ingestion of food

_____contact with skin

_____airborne particles

3. What treatment was necessary? ____

____

4. In detail, please provide instructions for the school to follow in the event the child experiences an allergic reaction while in school (i.e. specific circumstances when medication should be given.)

____

____

____

____

Physician's Signature____

Date ____

********In addition, please complete attached Medication Order form***