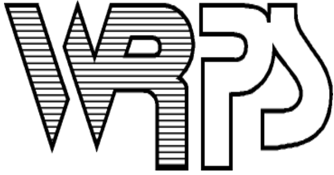
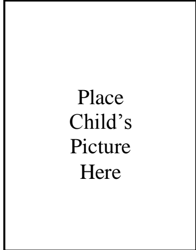


SEVERE ALLERGY QUESTIONNAIRE

WISCONSIN RAPIDS PUBLIC SCHOOLS

Student Name: ______________________________________ D.O.B. _________ Teacher: __________________________

Allergy to: ____



Asthmatic _____ YES* _____ NO *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms
Mouth	Itching &swelling of the lips, tongue, or mouth
Throat*	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	Shortness of breath, repetitive coughing, and/or wheezing
Heart*	"thready" pulse, "passing out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

ACTION FOR MINOR REACTION

1. If only symptom(s) are: ____, give ___________________________________.
   medication/dose/route
2. Call Mother _______________________________, Father __________________________________, or emergency contacts.
3. Call Dr. __________________________________ at ______________________________________.

If condition does not improve within 10 minutes, follow steps for major reaction listed below.

ACTION FOR MAJOR REACTION

1. If ingestion or sting is suspected and/or symptom(s) are: ____,

   give ____ IMMEDIATELY!
   medication/dose/route
2. Call rescue squad (911) – DO NOT HESITATE
3. Call Mother _________________________________, Father _______________________________, or emergency contacts.
4. Call Dr. _____________________________________ at ___________________________________.

Parent's Signature ____ Date ________________________________

See other side

THOMAS A. LENK EDUCATIONAL SERVICES CENTER
510 PEACH STREET * WISCONSIN RAPIDS, WISCONSIN 54494-4663 * 715-424-6700

EMERGENCY MEDICATIONS & CONTACTS

Student Name: ____ Date of Birth: _____________

Emergency medications (name, dosage) to be administered include:

Oral: ____

Injectable: ____

They will be located at:

_____ School Office/Health Office

_____ Student's Locker (Locker # _______ Combination # __________________)

_____ With student at all times

Transportation Plan: ☐ Medication available on bus ☐ Medication NOT available on bus
☐ Does not ride bus

I hereby give permission for my child, named above, to have possession of and administer this medication as needed while at school or school sponsored events.

______________________________ ________________________
Parent signature Date

I hereby certify that the above named student has received instruction on proper use of this medication. He/she may maintain possession and administer this medication as needed while at school or school sponsored events.

______________________________ ________________________
Physician signature Date

Emergency Contacts	
Name	
Relation	
Phone #	
Name	
Relation	
Phone #	
Name	
Relation	
Phone #	

Trained Staff Members	
Name	
Room #	
Name	
Room #	
Name	
Room #	
Name	
Room #	

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