SCOTCH PLAINS FANWOOD SCHOOL DISTRICT

ALLERGY REACTION INTERVIEW

Student Name_____

Date of Birth_____ Person giving history_____

History of allergic reaction to:_____

1. Date of most recent reaction_____
2. Type of reaction (symptoms/problems [i.e., hives, swelling of face, difficulty breathing, etc.])
   _____
   _____
3. What treatment/medication was given? _____
4. Did the doctor prescribe medication to be given for future exposures (i.e., accidental eating of allergic food or allergic reaction to insect sting)?_____no _____yes; name of medication_____
5. Were there previous reactions to the allergen listed above?
   _____no. _____yes; please give dates and reactions: _____
   _____
6. Does the student have any additional allergies or asthma?_____no
   _____yes; please specify:_____
7. May we share this information with staff who need to know?
   _____no _____yes
8. For a younger student may we post a picture of the child to ensure safety?
   _____no _____yes
9. Does the student:
   _____Have knowledge of the known allergy?
   _____Know the name of the medication, should contact occur?
   _____Able to self- administer the medication?
   _____Wear a medic-alert bracelet or necklace?

Date of interview_____

Signature of Parent or Guardian_____

Nurse's Signature_____ Med form given?_____

Dates reviewed:_____ _____ _____ _____