Name: _____
Last Name *First Name* *Middle Name*

DOB: _____ Gender: M F CIF: _____

Allergic Reaction Questionnaire
(ARQ)

Saint Paul Public Schools

Please **complete both sides** of this form and return to the Health Office.
(The following information will be shared with necessary school personnel. It will help us take care of your child at school.)

Date Completed: _____
School Year: _____

	Person to Contact:	Relationship:	Phone *(Work/Home/Cell)*:	Phone *(Work/Home/Cell)*:
1.			( )	( )
2.			( )	( )

Health Care Provider:	Clinic:	Phone:
		( )

Health Insurance: ___ Private ___ Medical Assistance ___ MN Care ___ No Insurance

1. Has your child been diagnosed with allergies/anaphylactic reactions by a Health Care Provider (HCP)? ___ No ___ Yes
   Are allergies life threatening? ___ No ___ Yes
2. Your child's age at diagnosis of allergies/anaphylactis? ____
3. Does your child have asthma/breathing problems? ___ No ___ Yes
4. Please ✓ what usually triggers *(starts)* your child's allergy attack/episode:

☐	Peanuts	☐	Tree Nuts	☐	Insect Stings (*kind:*)
☐	Seafood	☐	Eggs	☐	Animal (*list:*)
☐	Latex	☐	Soy	☐	Medications (*list:*)
☐	Fish			☐	Dairy Products (*list:*)
☐	Other: _____				

5. How soon after contact does your child react? ___ Minutes ___ Hours ___ Days
6. When was the last time that your child was treated for an allergic reaction? _____
7. In the past, how often has your child been treated in the emergency room?
   ___ 0 times ___ 1 time ___ 2 times ___ 3 times ___ More than 3 times
8. When was the last time your child received Epinephrine *(EpiPen or TwinJet)* for an alleric reaction? _____
9. Please ✓ your child's usual signs/symptons of a anaphylaxis:

System:	Symptoms:
Mouth	Itching & swelling of: ___ Lips ___ Tongue ___ Mouth
Throat	Itching and/or a sense of: ___ Tightness in the throat ___ Hoarseness ___ Hacking cough
Skin	___ Hives ___ Itchy rash ___ Swelling about the face or extremeties
Gut	___ Nausea ___ Stomach cramps __ Vomiting ___ Diarrhea
Lung	___ Shortness of breath ___ Repetitive coughing ___ Wheezing
Heart	___ "Thready" pulse ___ "Passing out"
Other	___ Anxiety/Restlessness

10. Does your child react when allergen is touched? ___ No ___ Yes Which allergen: _____
11. Does your child react when they smell or inhale allergen? ___ No ___ Yes Which allergen: _____
12. Does your child recognize these signs/symptons? ___ No ___ Yes
13. Does your child know how to avoid allergens *(causes of allergic/anaphylactic reactions)*? ___ No ___ Yes

Complete reverse side

14. Please list the medications your child takes to treat allergies *(everyday medications and medications taken when needed)*:

ALLERGY MEDICATIONS TAKEN AT HOME:

Medication Name?	How Much?	When is it Taken?

ALLERGY MEDICATIONS TO BE TAKEN AT SCHOOL:

Medication Name?	How Much?	When is it Taken?

Please list anything else you use for your child's allergies *(home remedies, etc.)* _____

_____

15. If your child has an EpiPen or TwinJet:
    a. Has he/she received training on how to self-administer? ___ No ___ Yes
    b. Has he/she ever self-administer? ___ No ___ Yes

16. Please add anything else that you would like the Health Office to know about your child's allergies. _____

_____

If your child's allergy status changes, please inform the Health Office.

Authorization:

- The purpose of this form is to facilitate communication between the health care provider and the Health Office as it relates to your child's allergy so as to meet your child's need in the school setting and to ask for your consent, or authorization, to request information from your health care provider and to release information to your health care provider from Saint Paul Public Schools (SPPS) professional staff.
- I agree that my child's care provider may release information to the SPPS professional staff, and/or request information from SPPS professional staff as it relates to my child's allergy.
- I agree that SPPS professional staff may release information to the health care provider and/or request information from the health care provider as it relates to my child's allergy.
- Legally, you may refuse to sign. Services are not conditioned upon this release of information.
- I understand that the consent takes effect the day that I sign it and expires one year from the date of my signature.
- I understand that I may revoke this consent at any time by giving written notification.
- It is the practice of SPPS not to redisclose records without consent.
- A photocopy/fax of this consent, which has not been altered, will be treated in the same manner as the original.
- You may ask for a copy of the records disclosed.

_____ _____

Parent/Guardian Signature *Date*