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? ____

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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.)

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Physician's Signature____
Date ____

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