

Michigan School Food Allergy & Asthma Policy Questionnaire

Name: _____

Address: _____

City: _____ Zip: _____ Phone: (_____) _____

Email: _____

School District: _____ School Name: _____

Age: _____ Grade: _____ Does this child have Asthma? Yes No Private School? Y N

Food Allergies (list) _____

Other Allergies (such as latex; please list): _____

Please circle your response(s) to the following questions:

I have provided the following emergency medications to remain at the school:

Epinephrine Auto-Injector(s) Antihistamine (such as Benadryl®) Asthma Inhaler Other _____

The school keeps these emergency medications in the:

Classroom Office Other (specify location) _____

During school hours & after hour's school events, the medication storage cabinet in the school is: Locked Un-locked

IF it is locked, who has the key(s)? _____

My child's physician has certified my child to: Self Carry Self-Administer Not approved to self-carry or self-administer

IF approved for self-carrying his/her medication:

My child carries the following medications:

Epinephrine Auto-Injector Antihistamine (such as Benadryl®) Asthma Inhaler Other (specify) _____

Did the school or district require an additional permission form completed & signed by the physician to permit self-carrying and/or self administration of his/her medication (i.e. in addition to the "permission to administer medication" form)? Yes No

My child does NOT self-carry his or her emergency medication(s) because:

Child is too young Child is not mature enough Child is too forgetful Not aware that it is possible

Other (specify): _____

Has your child had an allergic reaction at school in the past 24 months? Yes No

IF yes, what medication was administered for the reaction? (circle all that apply) Epinephrine Antihistamine Asthma Inhaler

No medication given I don't know Other (specify): _____

IF medication was administered, WHO gave the medication to your child?

Principal Nurse Teacher Secretary Bus Driver Self-administered

Other (specify): _____

Was the child transported to the emergency room for the allergic reaction? Yes No

IF yes, by whom? Child's parent/guardian Ambulance/EMS Other (specify): _____

Please answer the following questions about both your school district & your child's school:

	<u>School District</u>	<u>Your Child's School</u>
Does your school or school district currently have a written policy for students with allergies to food or other substances ?	Y N	Y N
Does your school or school district currently have a written policy for students with asthma ?	Y N	Y N
Does your school require a specific form for a food allergy action plan , or can you submit the information on the form of your choice? (circle)	Specific Form Required My Choice of Form	Specific Form Required My Choice of Form
Does your school require a specific form for an asthma action plan , or can you submit the information on the form of your choice? (circle)	Specific Form Required My Choice of Form	Specific Form Required My Choice of Form
Does your district or your child's school employ a school nurse?	Y N	Y N
IF your school has a nurse, is the nurse on site at your child's school part time or full time? (circle one)	Part Time	Full Time
IF the school DOES NOT have a school nurse, who is responsible for food allergy and/or asthma action plans? (circle)	Principal Social Worker Secretary Administrator Other (please specify) _____	
Do you have a 504 plan on file with the school?	Yes	No
Do you have a Food Allergy Action Plan on file with the school?	Yes	No
Do you have an Asthma Action Plan on file with the school?	Yes	No
IF you choose the form, which form(s) do you use? (check all that apply)		
<input type="checkbox"/> I Created My Own Form(s)		
<input type="checkbox"/> Food Allergy & Anaphylaxis Network (FAAN) Food Allergy Action Plan *		
<input type="checkbox"/> MI Dept. Of Community Health (MDCH) School Based Asthma Form *		
<input type="checkbox"/> Asthma & Allergy Foundation of America (AAFA):	<input type="checkbox"/> Asthma Action Plan *	<input type="checkbox"/> Asthma & Allergy Combined Form *
<input type="checkbox"/> Other (please indicate source) _____		

We need examples of the following documents & forms from as many schools & districts as possible:

- Written food allergy and/or asthma policies (school specific and district wide policies).
 - Permission to self-carry and/or self-administer medication forms
 - Permission to administer medication forms
 - Food allergy and/or asthma action plans that YOU created (i.e. without using a template from FAAN, AAFA, MDCH)
 - Specific emergency care plan forms that are required by your school for food allergic &/or asthmatic children (blank, if possible)
- (*NOTE: We do not need the following standardized forms FAAN's Food Allergy Action Plan, AAFA's Asthma Care Plan, AAFA's Asthma & Allergy Plan, MDCH School Based Asthma Forms)

Please send this completed questionnaire and copies of your school/school district forms (blank, if possible) **by January 15th, 2007 to:**

Melissa Dalton Circle of Food Allergic Families 7058 Rolling Hills Drive Waterford, MI 48327