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Food Allergy and Anaphylaxis

Health History Form

Student: _____DOB: _____

Parent(s)/Guardian(s): _____ Date: _____

Home Phone: _____ Work: _____ Cell:_____

School: _____Grade/Section: _____

Primary Healthcare Provider: _____ Phone: _____

Allergy Specialist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a health care provider? YES _____ NO _____

2. History and Current Status

a. What is your child allergic to?

_____ Peanuts _____ Eggs _____Milk _____ Latex _____Soy _____ Insect Stings
_____Fish/Shellfish _____Tree nuts (walnuts, pecans, etc.) _____ Chemicals: _____
_____Vapors: _____ _____Other: _____

b. Age of student when allergy first discovered: _____

c. How many times has student had a reaction? _____Never _____ Once

More than once, explain: _____

d. Explain their past reaction(s): _____

e. Symptoms: _____

_____

3. Triggers and Symptoms

a. What are the early signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say.) _____

b. How does your child communicate his/her symptoms? _____

c. How quickly do symptoms appear after exposure to food(s)? _____secs. _____mins. ____hrs. ____days

d. Please check the symptoms that your child has experienced in the past:

Skin: ___Hives ___ Itching ___ Rash ___ Flushing ___ Swelling (face, arms, hands, legs)

Mouth: ___ Itching ___ Swelling (lips, tongue, mouth)

Abdominal: ___ Nausea ___ Cramps ___ Vomiting ___ Diarrhea

Throat: ___ Itching ___ Tightness ___ Hoarseness ___ Cough ___ Wheezing

Lungs: ___ Shortness of breath ___ Repetitive cough

Heart: ___ Weak pulse ___ Loss of consciousness

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4. Treatment

a. How have past reactions been treated? _____

b. How effective was the student's response to treatment? _____

c. Was there and emergency room visit? ___ No ___ Yes, explain: _____

d. Was the student admitted to the hospital? ___ No ___ Yes, explain: _____

e. What treatment or medication has your health care provider recommended for use in an allergic reaction:
_____
_____

f. Has your healthcare provider provided you with a prescription for medication _____ No ____ Yes

g. Have you used the treatment or medication? ____ No ____ Yes

h. Please describe any side effects or problems your child had in using the suggested treatment: _____
_____

5. Self-Care

a. Is your child able to monitor and prevent their own exposures? ____ No ____ Yes

b. Does your child:

1) Know what foods to avoid ____ No ____ Yes

2) Ask about food ingredients ____ No ____ Yes

3) Read and understand food labels ____ No ____ Yes

4) Tell an adult immediately after an exposure ____ No ____ Yes

6) Tell peers and adults about the allergy ____ No ____ Yes

7) Firmly refuse a problem food ____ No ____ Yes

6. Family/Home

a. How do you feel that the whole family is coping with your student's food allergy? _____

b. Does your child carry epinephrine in the event of a reaction? ____ No ____ Yes

c. Has your child ever needed to administer that epinephrine? ____ No ____ Yes

d. Do you feel that your child needs assistance in coping with his/her food allergy? ____ No ____ Yes

If yes, Explain:_____

7. General Health:

a. How is your child's general health other than having a food allergy? _____

b. Does your child have other health conditions?_____

c. Hospitalizations?_____

d . Does your child have a history of asthma? ____ No ____ Yes

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e. Please add anything else you would like the school to know about your child's health: _____
_____

8. Notes:

Who provide health history? _____ Date: _____

Reviewed by RN: _____ Date: _____