WEST NORTHFIELD SCHOOL DISTRICT 31

Family Allergy Health History Form

Student Name: _____Date of Birth:_____
Parent/Guardian:_____Today's Date: _____
Home Phone:_____Work:_____Cell:_____
Primary Physician: _____Phone: _____
Allergist:_____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ❑ No ❑ Yes

2. History and Current Status

a. What is your child allergic to?

❑Peanuts ❑ Insect Stings
❑Eggs ❑ Fish/Shellfish
❑Milk ❑ Chemicals _____
❑Latex ❑ Vapors _____
❑Soy ❑ Tree Nuts (walnuts, pecans, etc.)
❑ Gluten ❑Other_____

b When and how did you first become aware of your child's allergy? :_____
c. Age of student when allergy first discovered:_____
d. How many times has student had a reaction since discovery?
❑Never ❑ Once ❑ More than once, explain:
_____
e. Explain their past reaction(s):_____
f. Symptoms:_____
g. Are the food allergy reactions: ❑Same ❑Better ❑Worse
h. When was the last time your child had an allergic reaction?
_____

3. Trigger and Symptom

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	❑ Breathing	❑Swallowing
Lungs:	❑ Shortness of breath		❑ Repetitive cough		❑ Wheezing	
Heart:	❑ Weak pulse	❑ Loss of consciousness		❑ Dizziness	❑Confusion	❑ Paleness

4. Treatment

a. How have past reactions been treated? _____

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

c. Was there an emergency room visit? ❑ No ❑ Yes, explain: _____

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

e. What treatment or medication (either prescription or over-the-counter medication) has your healthcare provider recommended for use in allergic reaction?

_____

f. Has your child's physician 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 has in using the suggested treatment:_____

_____

I. If medication is required while your child is at school, the enclosed Emergency Action Plan (EAP) form must be completed by a licensed medical provider and parent/guardian.

I. If medication is required while your child is at school, the enclosed Administration of Medication and/or Self-Administration form must be completed as well.

5. Self-Care

a. Is your student able to monitor and prevent their own exposures?	❑ No	❑ Yes
b. Does your student		
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
5. Wear a medical alert bracelet, necklace, watchband	❑ No	❑ Yes
6. Tell peers and adults about the allergy	❑ No	❑ Yes
7. Firmly refuses a problem food	❑ No	❑ Yes
c. Does your child know how to use emergency medication?	❑ No	❑ Yes_____
d. Has your child ever administered their own emergency medication?	❑ No	❑ Yes_____
e. Does your child carry epinephrine in the event of a reaction?	❑ No	❑ Yes
f. Has your child ever needed to administer the epinephrine?	❑ No	❑ Yes
g. Do you feel child needs assistance in coping with his/her food allergy?	❑ No	❑ Yes

6. Classroom / Lunchroom/ Extracurricular Activities / Field Trips

a. What accommodations have you provided in the home setting that have been effective in reducing/ eliminating your child's exposure to the allergen? Please explain. _____

_____

_____

b. Please describe any specific concerns you may have regarding your child's exposure to this allergen while at school. _____

_____

c. Please describe the steps you would like us to take if your child is exposed to this allergen at school. _____

_____

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

If yes, does he/she have an Asthma Action Plan? ❑ No ❑ Yes

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

_____

8. Additional Notes:

Parent / Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____

Adapted with permission – Washington State Guidelines for Anaphylaxis