Student Severe Allergy Health History

AA-1

Student Name____ Date of Birth_______________ Today's Date____________________
Parent/Guardian ______________________________________ School/Grade/Teacher______________________________________
Home Phone____________________________ Work Phone_________________________ Cell Phone___________________________
Primary Healthcare Provider____ 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 ❒ Tree nuts (almonds, pecans, etc)
❒ Eggs ❒ Fish/Shellfish
❒ Milk ❒ Wheat
❒ Latex ❒ Chemicals____________
❒ Soy ❒ Insect stings
❒ Other______________________________

b. Age of student when allergy discovered_________
c. How many times has student had a reaction?
❒Never ❒Once ❒More than once, explain:
____
d. Explain his/her past reaction(s)_________________
e. Symptoms__________________________________
f. Are the allergy reactions :❒Same ❒Better ❒Worse

3. Trigger 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 the allergen?_____secs ______mins _______hrs _______days
d. Please check the symptoms 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	
Lungs	❒Shortness of breath	❒Repetitive cough	❒Wheezing		
Heart	❒Weak pulse	❒Dizziness	❒Loss of consciousness		

4. Treatment

a. How have past reactions been treated?____
b. How effective was the treatment? What was the student's response?____
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 has your healthcare provider recommended for use in an allergic reaction?
____
f. Has your healthcare provider given you a prescription for medication? ❒No ❒Yes, name_____________________________
g. Have you used the treatment or medication? ❒No ❒Yes
h. Please describe any side effects or problems your child had in using a suggested or prescribed treatment: ___________________
____
____

5. Self Care

a. Is your student able to monitor and prevent his/her own exposures? ❐No ❐Yes

b. Does your student:

1. Know what situations/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 severe allergy ❐No ❐Yes
7. Firmly refuse problem/possibly allergic food ❐No ❐Yes

c. Does your child know how to use emergency medication? ❐No ❐Yes______________

d. Has your child ever administered his/her own medication? ❐No ❐Yes______________

6. Family/Home

a. How do you feel the whole family is coping with your student's severe 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 your child needs assistance in coping with his/her severe allergy?___________________________________

7. General Health

a. How is your child's general health other than having a severe 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 at school? ❐No ❐Yes

Rescue inhaler at school? ❐No ❐Yes

e. Please add anything else you would like me to know about your child's health__________________________________
____

8. Notes:

I authorize this information to be shared with all school staff as needed. I authorize reciprocal release of information related to severe allergies between the nurse at school and my child's healthcare provider.

Parent/Guardian Signature____**Date**____________

Reviewed by Nurse at School____**Date**____________

Adapted with permission – Washington State Guidelines for Anaphylaxis