Health Care District
PALM BEACH COUNTY

Allergy Health History Form

School Year: _____ School: _____

Student Name: _____ Student #

DOB: _____ Sex: M / F Grade: ____ Teacher: _____

Parent(s)/Guardian: _____ Phone _____

Phone _____ Phone _____ Phone _____

Physician_____ Phone_____

1. **Does your child have a diagnosis of an allergy from a healthcare provider?** ☐ No ☐ Yes
2. **History**

What is your child allergic to?

☐ Peanuts ☐ Insects _____
☐ Eggs ☐ Fish/Shellfish
☐ Milk ☐ Tree Nuts (walnuts, pecans, etc.)
☐ Latex ☐ Soy
☐ Other: _____

Age of child when allergy first discovered:_____

How many times has s/he had a reaction?

☐ Never ☐ Once ☐ More than one, explain:

_____

Explain their past reaction(s):_____

_____

3. **Trigger and Symptoms**

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

_____

How quickly do symptoms appear after exposure to allergen(s)? ___secs. ___mins. ___hrs. __days

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

Skin:	☐ Hives	☐ Itching	☐ Flushing	☐ Rash	☐ Swelling *(face, arms, hands, legs)*
Mouth:	☐ Itching	☐ Swelling *(lips, tongue, mouth)*			
Abdominal:	☐ Nausea	☐ Cramps	☐ Vomiting	☐ Diarrhea	
Throat:	☐ Itching	☐ Tightness	☐ Cough	☐ Hoarseness	
Lungs:	☐ Wheezing	☐ Repetitive Cough		☐ Shortness of breath	
Heart:	☐ Weak pulse	☐ Loss of consciousness			

4. **Treatment**

How have past reactions been treated? _____

How effective was the child's response to treatment? _____

Was there an emergency room visit? ☐ No ☐ Yes, *explain:*_____

Was the child admitted to the hospital? ☐ No ☐ Yes, *explain:*_____

What treatment or medication has your healthcare provider recommended for use in an allergic reaction?

_____

Has your child's healthcare provider provided a prescription for medication? ☐ No ☐ Yes _____

Has your child used the treatment or medication? ☐ No ☐ Yes

Name_____ **DOB** _____ **Weight**_____**lbs**

5. Self Care

Does your child:

Know what foods/allergens to avoid	☐ No	☐ Yes	Ask adults about food ingredients	☐ No	☐ Yes
Read and understand food labels	☐ No	☐ Yes	Tell an adult immediately after an exposure	☐ No	☐ Yes
Wear a medical alert bracelet	☐ No	☐ Yes	Tell peers and adults about the allergy	☐ No	☐ Yes

Does your child know how to use emergency medication? ☐ No ☐ Yes

Has your child ever administered their own emergency medication? ☐ No ☐ Yes

Does your child carry epinephrine in the event of a reaction? ☐ No ☐ Yes

6. General Health

Does your child have a history of asthma? ☐ No ☐ Yes-(Higher risk of severe reaction)

Does your child have other health conditions?_____

Hospitalizations?_____

Allergy Action Plan

Child extremely reactive to the following: _____

Any SEVERE SYMPTOMS after suspected or known exposure:
One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, cramping pain

1. **Inject epinephrine immediately**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications;*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis) USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. **Give antihistamine if ordered**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications

Epinephrine(Brand and dose): _____ ☐ 0.3mg IM ☐ 0.15mg IM

Antihistamine(Brand and dose):_____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

☐ Consent for self administration/self-carry (provided the school nurse determines it is safe and appropriate)

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given if applicable (See orders). For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

- I give the School Nurse my permission to follow the above emergency measures to assure my child's health and safety.
- I give the School Nurse my permission to contact my child's health care provider for information relevant to his/her medical condition as determined appropriate for my child's health and safety.
- I give the School Nurse my permission to share medical information with school staff on a "need to know" basis, if he/she determines this information is necessary to assure my child's health and safety.
- I will notify the School Nurse and teachers if there is any change in medication, treatment or medical condition.

_____ _____

Parent/Guardian Signature Date