

# Allergy Health History Form

School Year: \_\_\_\_\_

School: \_\_\_\_\_

<b>Student Name:</b> _____						<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>								
						Student #								
DOB: _____	Sex: M / F	Grade: _____	Teacher: _____											
Parent(s)/Guardian: _____			Phone _____											
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?

<input type="checkbox"/> Peanuts	<input type="checkbox"/> Insects _____
<input type="checkbox"/> Eggs	<input type="checkbox"/> Fish/Shellfish
<input type="checkbox"/> Milk	<input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)
<input type="checkbox"/> Latex	<input type="checkbox"/> Soy
<input type="checkbox"/> 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:

- |                   |                                     |  |  |                                     |  |
|-------------------|-------------------------------------|--|--|-------------------------------------|--|
| <b>Skin:</b>      | <input type="checkbox"/> Hives      | <input type="checkbox"/> Itching                               | <input type="checkbox"/> Flushing            | <input type="checkbox"/> Rash       | <input type="checkbox"/> Swelling <i>(face, arms, hands, legs)</i> |
| <b>Mouth:</b>     | <input type="checkbox"/> Itching    | <input type="checkbox"/> Swelling <i>(lips, tongue, mouth)</i> |  |                                     |  |
| <b>Abdominal:</b> | <input type="checkbox"/> Nausea     | <input type="checkbox"/> Cramps                                | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Diarrhea   |  |
| <b>Throat:</b>    | <input type="checkbox"/> Itching    | <input type="checkbox"/> Tightness                             | <input type="checkbox"/> Cough               | <input type="checkbox"/> Hoarseness |  |
| <b>Lungs:</b>     | <input type="checkbox"/> Wheezing   | <input type="checkbox"/> Repetitive Cough                      | <input type="checkbox"/> Shortness of breath |                                     |  |
| <b>Heart:</b>     | <input type="checkbox"/> Weak pulse | <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes, <i>explain:</i> _____
Was the child admitted to the hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes, <i>explain:</i> _____
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? <input type="checkbox"/> No <input type="checkbox"/> Yes _____
Has your child used the treatment or medication? <input type="checkbox"/> No <input type="checkbox"/> 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: \_\_\_\_\_

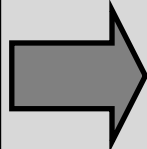
#### Any SEVERE SYMPTOMS after suspected or known exposure:

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



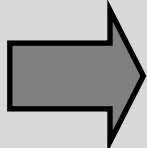
#### 1. Inject epinephrine immediately

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