



Family Food Allergy Health History Form

Student Name: _____ Date of Birth: _____
 Parent/Guardian: _____ Today's Date: _____
 Home Phone: _____ Work: _____ Cell: _____
 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

<p>a. What is your child allergic to?</p> <p><input type="checkbox"/> Peanuts <input type="checkbox"/> Insect Stings</p> <p><input type="checkbox"/> Eggs <input type="checkbox"/> Fish/Shellfish</p> <p><input type="checkbox"/> Milk <input type="checkbox"/> Chemicals _____</p> <p><input type="checkbox"/> Latex <input type="checkbox"/> Vapors _____</p> <p><input type="checkbox"/> Soy <input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)</p> <p><input type="checkbox"/> Other: _____</p>	<p>b. Age of student when allergy first discovered: _____</p> <p>c. How many times has student had a reaction?</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Once <input type="checkbox"/> More than once, explain: _____</p> <p>d. Explain their past reaction(s): _____</p> <p>e. Symptoms: _____</p> <p>f. Are the food allergy reactions: <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse</p>
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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 food(s)? _____secs. _____mins. _____hrs. _____days
- d. Please check the symptoms that your child has experienced in the past:
- | | | | | | |
|-------------------|--|---|-------------------------------------|-----------------------------------|---|
| Skin: | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching | <input type="checkbox"/> Rash | <input type="checkbox"/> Flushing | <input type="checkbox"/> Swelling (face, arms, hands, legs) |
| Mouth: | <input type="checkbox"/> Itching | <input type="checkbox"/> Swelling (lips, tongue, mouth) | | | |
| Abdominal: | <input type="checkbox"/> Nausea | <input type="checkbox"/> Cramps | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | |
| Throat: | <input type="checkbox"/> Itching | <input type="checkbox"/> Tightness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Cough | |
| Lungs: | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Repetitive Cough | | <input type="checkbox"/> Wheezing | |
| Heart: | <input type="checkbox"/> Weak pulse | <input type="checkbox"/> Loss of consciousness | | | |

4. Treatment

<p>a. How have past reactions been treated? _____</p> <p>b. How effective was the student's response to treatment? _____</p> <p>c. Was there an emergency room visit? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p>d. Was the student admitted to the hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p>e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction? _____</p>	<p>f. Has your healthcare provider provided you with a prescription for medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>g. Have you used the treatment or medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>h. Please describe any side effects or problems your child had in using the suggested treatment: _____</p>
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5. Self Care

a. Is your student able to monitor and prevent their own exposures?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Does your student:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
1. Know what foods to avoid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Ask about food ingredients	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Read and understands food labels	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Tell an adult immediately after an exposure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Wear a medical alert bracelet, necklace, watchband	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. Tell peers and adults about the allergy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7. Firmly refuses a problem food	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Does your child know how to use emergency medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
d. Has your child ever administered their own emergency medication?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
c. Has your child ever needed to administer that epinephrine?	<input type="checkbox"/> No <input type="checkbox"/> Yes
d. Do you feel that your child needs assistance in coping with his/her food allergy?	_____

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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, does he/she have an Asthma Action Plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes
e. Please add anything else you would like the school to know about your child's health:	_____ _____

8. Notes:

Parent / Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____