Allergy/Anaphylaxis History

Date_____

Student's Name_____DOB_____Grade_____
Primary Healthcare Provider: _____ Phone: _____
Allergist: _____Phone: _____

Does your child have a Section 504 Plan for this health condition? Yes_____ No _____

Has a healthcare provider diagnosed your child with severe allergies? Yes___ No ___ At what age?_____

Are your child's allergies life-threatening ____Yes ____No

Has your child required an emergency room visit or hospitalization due to allergies/anaphylaxis? Yes _____ No _____
If yes, explain _____
_____

What is your child allergic to? (Check all that apply)

- ☐ peanuts
- ☐ tree nuts
- ☐ eggs
- ☐ milk
- ☐ soy
- ☐ fish/shellfish
- ☐ latex
- ☐ insect stings
- ☐ medication, list medications
- ☐ Other, describe_____

Has your child been prescribed medication for the treatment of allergies, including emergency medications? Yes ____ No ____

List all medications prescribed for your child:

Medication Name	Dosage	Frequency	Will this medication be given at school Yes/No

How many times has your child had a reaction? _____

When was your child's last reaction? _____

What are the early signs of your child's reaction? _____

Please circle **ALL** 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	
Lungs:	Shortness of Breath				
Heart:	Weak pulse	Loss of Consciousness			

Has your child ever received "allergy shots"? ____Yes ____No, When: _____

What is your child's self-care level for his/her allergies at school?

- ☐ Independent management
- ☐ Assistance from staff
- ☐ Complete care from staff

How does your child communicate his/her symptoms? _____

Does your child:

- Know how to prevent his/her own exposure? NO YES
- Know what foods to avoid NO YES
- Ask 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, necklace, watchband NO YES
- Tell peers and adults about the allergy NO YES
- Firmly refuse a problem food NO YES
- Know how to use emergency medication? NO YES

Parent/Guardian Name:_____ Date: _____

Parent Guardian Signature: _____

Reviewed by RN: _____ Date: _____