HIGHLAND SCHOOL DISTRICT 203

SEVERE ANAPHYLACTIC ALLERGY HEALTH HISTORY FORM

Today's Date: _______________ School Year: _____________ School/Grade: ________________

Student Name: ____ Date of Birth: ________________

Parent/Guardian Name: ____

Home Phone: (_____)_________________ Work #: (_____)_______________ Cell #: (_____)________________

Primary Health Care Provider: ____

Clinic Name: ____ Phone #: (_____)____________________________

Allergist: ____

Clinic Name: ____ Phone #: (_____)____________________________

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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?	b. Age of student when allergy first discovered? ___________
☐ Peanuts ☐ Insect Stings	c. How many times has student had a reaction?
☐ Eggs ☐ Fish/Shellfish	☐ Never ☐Once ☐More than once, explain _____________
☐ Milk ☐ Chemicals___________________	____
☐ Latex ☐ Vapors______________________	d. Explain their past reaction(s): _______________________
☐ Soy ☐ Tree Nuts (walnuts, pecans, etc.)	e. Symptoms: _______________________________________
☐ Other: _____________________________	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.) ____

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b. How does your child communication their symptoms? _______________________________________

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c. How quickly do symptoms appear after exposure to the allergen(s): ☐ seconds ☐ minutes ☐ hours ☐ days

d. Please check they symptoms that 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		☐ Loss of consciousness		

4. Treatment

a. How have past reactions been treated? ____

b. How effective was the student's response to treatment? _____________________________________

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?

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f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes

g. Have you used the treatment or medication? ☐ No ☐ Yes

h. Please describe any side effects or problems your child had in using the suggested treatment: ________________

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5. Self Care

a. Is your student able to monitor and prevent their own exposure? ☐ No ☐ Yes

b. Does your student:

1. Know what foods to avoid ☐ No ☐ Yes
2. Ask about food ingredients ☐ No ☐ Yes
3. Read and understands food labels ☐ No ☐ Yes
4. Tell an adult immediately after an exposure ☐ No ☐ Yes
5. Wear a medical bracelet, necklace, watchband ☐ No ☐ Yes
6. Tell peers and adults about the allergy ☐ No ☐ Yes
7. Firmly refuses a problem food ☐ No ☐ Yes

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

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

6. Family/Home

a. How do you feel that the whole family is coping with your student's food allergy? ____________________

b. Does you 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 that your child needs assistance in coping with their food allergy? ____________________

7. General Health

a. How is your child's general health other than having a good allergy? ____________________

b. Does your child have other health conditions? ____________________

c. Hospitalizations? ____________________

d. Does your child have a history of asthma? ☐ No ☐ Yes

e. Please add anything else you would like the school to know about your child's health: ____________________

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8. Notes:

Parent/Guardian Signature: ______________________________ **Date:** ______________

Reviewed by R.N.: ______________________________ **Date:** ______________