## ISD 282 St. Anthony/New Brighton Schools

## Student Allergy Health History Form

Student Name: ____________________________________________ Date of Birth: _____________

Parent/Guardian Name: ______________________________________ 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:**

What is your child allergic to?

___ Peanuts ___Soy

___ Eggs ___ Insect Stings __________

___ Milk ___ Fish/Shellfish

___ Latex ___ Chemicals ___________

___ Soy ___ Tree Nuts ___________

___ Other __________________________

Age of Student when allergy discovered: _________

How many times has the student had a reaction?

_____ Never _____ Once ____ More,

_____________________________________

Explain their past reactions:

_____________________________________

Symptoms:

_____________________________________

**3. Trigger and Symptoms:**

- What are the early signs and symptoms of your student's allergic reaction? (Be specific; include things the student might say.)
  ______________________________________________________________________
  ______________________________________________________________________
- How does your child communicate his/her symptoms? ___________________________________
- How quickly do symptoms appear after exposure to allergen? ____ secs. ____ mins. ____ hrs ____ days
- Please circle the 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 | | | |

How have past reactions been treated? _____________________________________________

Was there an emergency room visit? ____ No ____Yes, explain ___________________________

Was the student admitted to the hospital? _____ No ____Yes, explain _______________________

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

______________________________________________________________________

Have you used the treatment medication? ___________________________________________

Did your child have any side effects from treatment? ________________________________

**5. Self Care:**

| | | |
|---|---|---|
| Is your student able to monitor and prevent their own exposures? | ____NO | ____ YES |
| Does your student: | | |
| • 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 exposure | ____NO | ____YES |
| • Wear a medical alert bracelet, necklace, watchband | ____NO | ____YES |
| • Tell peers and adults about the allergy | ____NO | ____YES |
| • Firmly refuse problem foods | ____NO | ____YES |
| Does your child know how to use emergency medication (EPIPEN) | ____NO | ____YES |
| Has your child ever administered their own emergency medication? | ____NO | ____YES |

**6. Middle School/High School:**

| | | |
|---|---|---|
| Does your child carry epinephrine in case of an allergic reaction? | ____NO | ____YES |
| Do you feel confident your child could self– administer if needed? | ____NO | ____YES |
| Has your child's doctor approved your child to self-administer? | ____NO | ____YES |

Please provide documentation of this approval to the Health Office using the Self Administration of Medication Form available on the MS and HS websites under the Health Services Tab.

**7. General Health:**

How is your child's general health other than having a food allergy? ________________________________________

Does your child have any other health conditions? ______________________________________________

Does your child have a history of asthma? ______NO ______YES *Please provide Asthma Action Plan

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

**8. Wilshire Park:**

Do you want your student to sit at the "Nut Free" table at lunch? _____No _____Yes _____My student can decide.

If your child is allergic to eggs, can they work with egg cartons in the classroom? ____No _____Yes

If your child is allergic to eggs, can they eat them in baked goods? _____No _____Yes

If your child is allergic to peanuts, are they able to eat foods that have been manufactured in the same facility as peanuts? _____No _____ Yes Comments_______________________________________________________

**9. Parent checklist for beginning of school year (Must be completed EACH year):**

**______ Food Allergy Action Plan completed w/ photo of student**

**______ EPIPEN properly labeled to your child's school (or with your self-carry student MS/HS)**

**______ Asthma Action Plan (if your child has asthma)**

**______ Asthma medication to your child's school (or with your self-carry student MS/HS)**

**______ Self Administration of Medication Form (MS/HS students who self-carry)**

**10. Do you want the bus company to have a copy of your child's Food Allergy Action Plan? _____NO _____Yes**

**Bus number(s): _______________**

**Parent/Guardian Signature: ______________________________________________ Date: ________________**

**Reviewed By: ____________________________________________________________ Date: ________________**