THE WINNETKA PUBLIC SCHOOLS DISTRICT 36

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ALLERGY HISTORY FORM

Food/Insect/Latex

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

Does your child have a diagnosis of an allergy from a healthcare provider: ___ No ___ Yes
Date of last appointment: _____ Testing done: _____
Date(s) of testing: _____ Any changes: _____
Date of Oral Immunotherapy/ "OIT" , if started: _____

ALLERGY TO: _____
_____

HISTORY AND CURRENT STATUS:

Please describe **FIRST** allergic reaction:

- Child's age: _____
- Describe initial signs and symptoms of first reaction:
  _____
  _____
  _____
- Describe the progression of first reaction (respiratory distress/anaphylaxis?):
  _____
  _____
- Medical treatment given: _____
- Has your child had any allergic reactions since the first reaction: _____ Yes _____ No
- Are the food allergy reactions: _____ Same _____ Better _____ Worse
- When was the **LAST** reaction: _____

TRIGGER AND SYMPTOMS:

- What are the early signs and symptoms of your child's allergic reaction? Be specific, include things he or she may say. _____
  _____
  _____
- How does your child communicate his/her symptoms: _____
  _____
- How quickly have symptoms appeared after exposure to food(s)?
  _____ Seconds _____ Minutes _____Hours _____ Days

Please check the symptoms that your child has had 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			
Other:	❑ _____	❑ _____	❑ _____	❑ _____	❑ _____

TREATMENT

- Treatment used in the past:
  _____
- How effective was the child's response to treatment:
  _____
- Has your healthcare provider/allergist provided you with a prescription for emergency medication? _____ No _____ Yes Have you ever used this medication (explain) : _____
  _____
- Describe any side effects or problems your child had when using prescribed treatment: _____
  _____
- Was there an emergency room visit: _____ No _____ Yes
- Was the child admitted to the hospital: _____ No _____ Yes

SELF CARE

- Is your child able to monitor and prevent their own exposures: _____ No _____Yes
- Does your child:
  - ❖ 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 band: _____ No _____ Yes
  - ❖ Tell peers and adults about the allergy: _____ No _____ Yes
  - ❖ Firmly refuses a problem food: _____ No _____ Yes
- Does your child know how to use the emergency medication? _____ No _____ Yes
- Has your child ever administered their own medication? _____ No _____ Yes
- Does your child carry his own medication? _____ No _____ Yes

- Does your child also have **ASTHMA**? _____ No _____ Yes
- If yes, will your child have an asthma inhaler at school? _____ No _____ Yes
  - ❖ Inhaler will be kept in health office _____ No _____ Yes
  - ❖ Inhaler will be carried by student _____ No _____ Yes
- Does your child have an asthma action plan? _____ No _____ Yes
  - ❖ Other asthma medications taken at home or school _____
    _____

OTHER

- Please add anything else you would like us to know regarding your child's health history and/or current health:
  _____
  _____
  _____
  _____

PLEASE COMPLETE FOR ELEMENTARY STUDENTS:

- Which days will child stay for lunch? M T W TH F
- Will child sit at allergen-free table? ____ Yes ____ No
- Does your child require any other lunch accommodations? ____ Yes ____ No
  - ❖ If yes, explain: _____
- Is your child allowed to eat snacks/treats brought in for celebrations?
  _____
- Is your child allowed to eat food when labels state:
  - ❖ "May contain [allergen]" ___ No ___Yes
  - ❖ "Manufactured in a facility that uses [allergen] ingredients" ___ No ___ Yes
  - ❖ "Manufactured in a facility which processes [allergen]" ___ No ___ Yes
  - ❖ "Processed in a facility that uses [allergen]" ___ No ___ Yes
  - ❖ "Manufactured on equipment that processes products containing [allergen]" ___ No ___ Yes
  - ❖ "Manufactured on equipment that uses [allergen]" ___ No ___Yes
  - ❖ "Manufactured in a facility that processes [allergen], but not on the same equipment" ___ No ___ Yes
  - ❖ "Manufactured on shared equipment...may contain [allergen....] ___ No ___Yes

- Do you want to supply alternate safe snacks to keep in the classroom for snack time, special occasions, or special projects? ____ Yes ____ No

- Parent-supplied medications and action plans are kept in child's classroom. Do these items need to be kept in other locations also? ___ No ___ Yes
  - ❖ If yes, please explain: _____

Please check and initial to verify the following:

_____I have reviewed the existing allergy history information for my child.

_____I understand that my child's photo and allergy condition will be available to all school staff members in the interest of my child's health and safety.

_____After reviewing this allergy history, I verify that there are no changes needed to update my child's allergy history information at this time.

----------or----------

_____After reviewing this allergy history, I have added new information based on my child's recent health.

Parent/Guardian Signature: _____ Date: _____

Updated March, 2019