Individualized Healthcare Plan: Allergy Assessment

Student Name: _____Date of Birth: _____

Specific Allergens: _____

I. History: (Please be as specific as possible; use additional pages if necessary)

A. Medical and Surgical History: _____

_____

_____

_____

B. Number and severity of reactions to allergen(s): _____

_____

_____

_____

C. Specific signs and symptoms of an allergic reaction (mild to severe): _____

_____

_____

_____

D. Date of last allergic reaction: _____

E. Previous allergic reactions other than to above allergen: _____

_____

_____

F. Past history of episodes at school: _____

_____

_____

_____

_____

G. Past School environmental modifications and how well they worked to prevent reactions: _____

_____

_____

_____

_____

II. Current Status and Management

A. Current treatment plan for allergic reaction, including prescribed medications: _____

_____

_____

_____

B. Identification of potential sources of allergen in school environment: _____

_____

_____

_____

_____

C. List of alternatives or substitutions to avoid allergens, including commercially made products:

_____

_____

_____

_____

_____

_____

_____

_____

III. Self-Care:

A. Physical and cognitive ability to self-administer medications: _____

_____

B. Self-awareness of early signs/symptoms of an allergic reaction: _____

_____

C. Knowledge/ability to inform appropriate personnel when experiencing allergic symptoms and assist with tx:

_____

D. Physical &/or cognitive ability to explain his/her needs during an allergic reaction: _____

_____

E. Knowledge and ability to avoid allergen: _____

_____

IV. Psychosocial Status:

A. Effect of _____allergy on student's daily living activities: _____

_____

_____

B. Student's perception of what staff/peers think & feel about student having an allergy: _____

_____

_____

C. Student's affect, outlook, & general attitude toward the condition: _____

_____

_____

D. Student's ability to participate in normal activities of community & extra-curricular activities: _____

_____

_____

_____

E. Activity restrictions necessary due to possible allergen exposure: _____

_____

_____

_____

_____

Physician Information:

Name: _____

Address: _____

Phone Number:_____