Our Mission
To achieve educational excellence and to inspire a life-long passion for learning.

ALEXANDRIA
Public Schools

Our Vision
To be an extraordinary school district that tailors learning for each child, by working together!

NASN National Association of School Nurses

SEVERE (ANAPHYLACTIC) ALLERGY HEALTH HISTORY FORM

Please complete all questions. New forms are required each school year

Student Name:	Date of Birth:	School year:
Parent/Guardian:		
Home phone:	Work #:	Cell #:
Primary Healthcare Provider:		
Clinic Name:	Phone #:	
Allergist:		
Clinic Name:	Phone #:	

1. Does your child have a diagnosis of an allergy from a healthcare provider? ☐Yes ☐No

2. History and Current Status

a. What is your child allergic to?

☐Peanuts ☐Insect Stings
☐Eggs ☐Fish/Shellfish
☐Milk ☐Chemicals_____
☐Latex ☐Vapors_____
☐Soy ☐Tree Nuts (walnuts, pecans, etc.,)
☐Other: _____

b. Age of student when allergy first discovered? _____

c. How many times has student had reaction?
☐ Never ☐Once ☐More than once, explain_____
_____

d. Explain their past reaction(s): _____

e. Symptoms: _____

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.) _____
_____

b. How does your child communicate his/her symptoms? _____
_____

Adopted with permission – Washington State Guidelines for Anaphylaxis

c. How quickly do symptoms appear after exposure to the allergen(s):

☐secs ☐mins. ☐hrs. ☐days

d. Please check 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

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:

_____

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: _____

_____

5. Self-Care

a. Is your student able to monitor and prevent their own exposures?	☐No	☐Yes	
b. Does your student:			
1. Know how to avid their Allergan	☐No	☐Yes	
2. Ask about Allergan ingredients in foods/products	☐No	☐Yes	☐N/A
3. Read and understands food labels	☐No	☐Yes	☐N/A
4. Tell an adult immediately after an exposure	☐No	☐Yes	
5. Wear a medical alert bracelet, necklace, or watchband	☐No	☐Yes	

6. Tell peers and adults about the allergy ☐No ☐Yes
7. Firmly refuses a problem food ☐No ☐Yes ☐N/A

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 allergy? _____
b. Does your child carry epinephrine in the event of 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 his/her allergy? _____

7. General Health

a. How is your child's general health other than having a severe allergy? _____
b. Does your child have other health conditions? _____
c. Hospitalizations? _____
d. Does your child have a history of asthma? ☐No ☐Yes
   If Yes, does he/she have an Asthma Action Plan? ☐No ☐Yes
e. Please add anything else you would like the school to know about your child's health: _____
   _____

8. Notes:

Parent/Guardian Signature:	Date:
Health Paraprofessional:	Date:
Registered Nurse:	Date: