Edmonds School District

HS 27
Student Health Services
Allergy Information Form - Initial

Student:_____ Birthdate: _____ School:_____ Grade: _____Date:_____

The following information will help the nurse in determining any special needs for your student at school. Once completed, return this form to your school nurse. If your student's allergy is not food-related, skip questions related to food.

1. What is your student allergic to? ☐ Peanuts ☐ Tree Nuts ☐ Wheat* ☐ Whole Egg* ☐ Egg in baked products*
   ☐ Milk/Dairy* ☐ Soy* ☐ Sesame* ☐ Fish ☐ Shellfish
   ☐ Latex ☐ Bee/Insect Stings ☐ Other: _____
   (* means a Dietary Prescription Form is Indicated)
2. Did your student's healthcare provider tell you this allergy could be life-threatening? ☐ NO ☐ YES
3. Has your student been prescribed an EpiPen? ☐ NO ☐ YES
4. Has your student had allergy testing? ☐ NO ☐ YES, when & where: _____
5. **Does your student have asthma**? ☐ NO ☐ YES, triggers: _____
   Do they have prescribed asthma medicine? ☐ NO ☐ YES, what (daily & as needed): _____
6. Does your student have environmental or seasonal allergies? ☐ NO ☐ YES, to what: _____
   Do they take allergy medication? ☐ NO ☐ YES, what (daily & as needed): _____

FOOD RELATED

7. Will your student: ☐ Only bring food from home ☐ Purchase school meals ☐ Combination of home and school meals
   ☐ Requires Stop Purchases (no school meals allowed)

REACTION HISTORY

8. **Has your student reacted to allergen by: ☐ Eating/Ingesting food ☐Touching Food ☐ Smelling or Inhalation of Food**
9. How old was your student when the allergy was first discovered? _____
10. How many times has your student had a reaction? ☐ Never ☐ Once ☐ More than once: _____
    Date of last reaction: _____
11. How soon did reaction occur after contact with allergen? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐Unknown
    ☐ Other:
    _____
    _
12. Please describe reaction (be specific, early and late signs/symptoms, time from exposure, etc.): _____
    _____
    _____
13. Did you give medication? ☐ NO ☐ YES, what? _____
    Did medication resolve the reaction? ☐ YES ☐ NO, explain: _____
14. **Has an EpiPen been given before? ☐ NO ☐ YES, how many doses were given before symptoms resolved?** _____
15. **Has your student ever needed treatment at a clinic or hospital for an allergic reaction? ☐ NO ☐ YES, describe:** _____
    _____
16. Over time are reactions: ☐ Staying the same ☐ Getting better ☐ Getting worse ☐ Unknown

FOOD INDEPENDENCE AT SCHOOL/ALLERGY MANAGEMENT AT SCHOOL

17. Does your student:

Know what their allergy is?	☐ YES ☐ NO
Know how to read food labels and determine if a food is allergen-free?	☐ YES ☐ NO ☐N/A
Independently avoid foods that cause allergic reaction?	☐ YES ☐ NO ☐N/A
Does your student require Allergy Aware Seating in Cafeteria/Classroom?	☐ YES ☐ NO ☐N/A

Know not to share or trade food/utensils?	☐ YES ☐ NO ☐N/A
Know to tell an adult if they've had an exposure or are experiencing symptoms?	☐ YES ☐ NO
Know how to self manage an allergic reaction (5th grade and above) (*Requires medication order and authorization from nurse, parent and health provider.)	☐ YES ☐ NO

CARE COORDINATION

18. List primary care provider and specialists involved in your child's care:

Physician	Type of Provider	Date Last Seen	Phone

19. Does your student have health insurance? ☐ NO ☐ YES, which one? _____
20. Are you having challenges getting allergy medication or connecting with a doctor? ☐ NO ☐ YES
21. Is your student involved in school-sponsored activities or sports outside the school day?

    ☐ NO ☐ YES*, what? _____
22. *For elementary*: Do we have your permission for students in the classroom to know of this allergy? ☐ NO ☐ YES
23. **When riding the bus to or from school or on field trips should your student sit up front close to the driver? ☐ NO ☐ YES**
24. List EMERGENCY CONTACTS for your student:

(name) (relationship)	*(phone number)*	*(phone number)*
(name) (relationship)	*(phone number)*	*(phone number)*

SCHOOL PLANNING

Allergy to:	Severity:	Symptoms:	Notes
	☐ Mild ☐ Moderate ☐ Severe ☐ Life-Threatening	☐ Itching ☐ hives ☐ rash ☐ tingling ☐ swelling, where: ________________ ☐ cough ☐ wheeze ☐hoarseness ☐ difficulty breathing ☐ dizziness ☐ nausea ☐ cramps ☐ vomiting ☐ diarrhea ☐ eczema ☐ other: ______________________	
	☐ Mild ☐ Moderate ☐ Severe ☐ Life-Threatening	☐ Itching ☐ hives ☐ rash ☐ tingling ☐ swelling, where: ________________ ☐ cough ☐ wheeze ☐hoarseness ☐ difficulty breathing ☐ dizziness ☐ nausea ☐ cramps ☐ vomiting ☐ diarrhea ☐ eczema ☐ other: ______________________	
	☐ Mild ☐ Moderate ☐ Severe ☐ Life-Threatening	☐ Itching ☐ hives ☐ rash ☐ tingling ☐ swelling, where: ________________ ☐ cough ☐ wheeze ☐hoarseness ☐ difficulty breathing ☐ dizziness ☐ nausea ☐ cramps ☐ vomiting ☐ diarrhea ☐ eczema ☐ other: ______________________	

_______________________________________ ____________ ____________________

Parent/Guardian Signature & Relationship ***Date*** ***Email address***