



Deer Valley
Unified School District

Student Severe Allergy Health History



National
Association of
School Nurses

AA-1

Student Name _____ Date of Birth _____ Today's Date _____
 Parent/Guardian _____ School/Grade/Teacher _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 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

a. What is your child allergic to?

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Tree nuts (almonds, pecans, etc) |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish/Shellfish |
| <input type="checkbox"/> Milk | <input type="checkbox"/> Wheat |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Chemicals _____ |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Insect stings |
| <input type="checkbox"/> Other _____ | |

b. Age of student when allergy discovered _____

c. How many times has student had a reaction?

☐ Never ☐ Once ☐ More than once, explain:

d. Explain his/her 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? _____

c. How quickly do symptoms appear after exposure to the allergen? _____secs _____mins _____hrs _____days

d. Please check the symptoms your child has experienced in the past:

- | | | | | | |
|------------------|--|---|--|-----------------------------------|---|
| Skin | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching | <input type="checkbox"/> Rash | <input type="checkbox"/> Flushing | <input type="checkbox"/> Swelling (face, arms
hands, legs) |
| Mouth | <input type="checkbox"/> Itching | <input type="checkbox"/> Swelling (lips, tongue, mouth) | | | |
| Abdominal | <input type="checkbox"/> Nausea | <input type="checkbox"/> Cramps | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | |
| Throat | <input type="checkbox"/> Itching | <input type="checkbox"/> Tightness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Cough | |
| Lungs | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Repetitive cough | <input type="checkbox"/> Wheezing | | |
| Heart | <input type="checkbox"/> Weak pulse | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of consciousness | | |

4. Treatment

a. How have past reactions been treated? _____

b. How effective was the treatment? What was the student's response? _____

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 given you a prescription for medication? ☐ No ☐ Yes, name _____

g. Have you used the treatment or medication? ☐ No ☐ Yes

h. Please describe any side effects or problems your child had in using a suggested or prescribed treatment: _____

5. Self Care

a. Is your student able to monitor and prevent his/her own exposures?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Does your student:		
1. Know what situations/foods to avoid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Ask about food ingredients	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Read and understand food labels	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Tell an adult immediately after an exposure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Wear a medical alert bracelet, necklace, watchband	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. Tell peers and adults about the severe allergy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7. Firmly refuse problem/possibly allergic food	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Does your child know how to use emergency medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
d. Has your child ever administered his/her own medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____

6. Family/Home

a. How do you feel the whole family is coping with your student's severe allergy? _____		
b. Does your child carry epinephrine in the event of a reaction?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Has your child ever needed to administer that epinephrine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d. Do you feel your child needs assistance in coping with his/her severe 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If yes, does he/she have an Asthma Action Plan at school?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Rescue inhaler at school?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
e. Please add anything else you would like me to know about your child's health _____		

8. Notes:

I authorize this information to be shared with all school staff as needed. I authorize reciprocal release of information related to severe allergies between the nurse at school and my child's healthcare provider.

Parent/Guardian Signature _____ Date _____

Reviewed by Nurse at School _____ Date _____