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?

❒ Peanuts ❒ Tree nuts (almonds, pecans, etc)
❒ Eggs ❒ Fish/Shellfish
❒ Milk ❒ Wheat
❒ Latex ❒ Chemicals_____
❒ Soy ❒ Insect stings
❒ 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	❒Hives	❒Itching	❒Rash	❒Flushing	❒Swelling (face, arms
Mouth	❒Itching	❒Swelling (lips, tongue, mouth)			hands, legs)
Abdominal	❒Nausea	❒Cramps	❒Vomiting	❒Diarrhea	
Throat	❒Itching	❒Tightness	❒Hoarseness	❒Cough	
Lungs	❒Shortness of breath	❒Repetitive cough	❒Wheezing		
Heart	❒Weak pulse	❒Dizziness	❒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?	❒No	❒Yes
b.	Does your student:		
1.	Know what situations/foods to avoid	❒No	❒Yes
2.	Ask about food ingredients	❒No	❒Yes
3.	Read and understand food labels	❒No	❒Yes
4.	Tell an adult immediately after an exposure	❒No	❒Yes
5.	Wear a medical alert bracelet, necklace, watchband	❒No	❒Yes
6.	Tell peers and adults about the severe allergy	❒No	❒Yes
7.	Firmly refuse problem/possibly allergic food	❒No	❒Yes
c.	Does your child know how to use emergency medication?	❒No	❒Yes_____
d.	Has your child ever administered his/her own medication?	❒No	❒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?	❒No	❒Yes
c.	Has your child ever needed to administer that epinephrine?	❒No	❒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?	❒No	❒Yes
	If yes, does he/she have an Asthma Action Plan at school?	❒No	❒Yes
	Rescue inhaler at school?	❒No	❒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_____

Adapted with permission – Washington State Guidelines for Anaphylaxis