DALLAS INDEPENDENT SCHOOL DISTRICT

Food Allergy
(Document in EHR)

Health Services

Food Allergy Health History Form

Student: _____ ID#: _____ DOB: _____

Parent/Guardian: _____ Date: _____

Home Phone:_____Work:_____Cell:_____

School: _____Grade/Section: _____

Primary Healthcare Provider:_____ Phone: _____

Allergy Specialist:_____ Phone: _____

1. **Does your child have a diagnosis of an allergy from a health care provider?** ❑ No ❑ Yes
2. **History and Current Status**
   a. What is your child allergic to?
      ❑ Peanuts ❑ Eggs ❑ Milk ❑ Latex ❑ Soy ❑ Insect Stings
      ❑ Fish/Shellfish ❑ Tree nuts (walnuts, pecans, etc.) ❑ Chemicals:
      ❑ Vapors: _____ ❑ Other:_____
   b. Age of student when allergy first discovered:_____
   c. How many times has student had a reaction? ❑ Never ❑ Once
      ❑ More than once, explain:_____
   d. Explain their past reaction(s):_____
   e. Symptoms:_____
   f. Are the food allergy reactions: ❑ Same ❑ Better ❑ Worse
3. **Triggers 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 food(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 ❑ Wheezing
      Lungs: ❑ Shortness of breath ❑ Repetitive cough
      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 and emergency room visit? ❑ No ❑ Yes, explain: _____
   d. Was the student admitted to the hospital? ❑ No ❑ Yes, explain: _____

e. What treatment or medication has your health care 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 child able to monitor and prevent their own exposures? ❑ No ❑ Yes

b. Does your child:

1) Know what 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 allergy ❑ No ❑ Yes
7) Firmly refuse a problem food ❑ No ❑ Yes

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 food 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 that your child needs assistance in coping with his/her food allergy? ❑ No ❑ Yes

Explain: _____

7. General Health:

a. How is your child's general health other than having a food allergy? _____

b. Does your child have other health conditions?_____

c. Hospitalizations?_____

d . Does your child have a history of asthma? ❑ No ❑ Yes

Explain _____

e. Please add anything else you would like the school to know about your child's health: _____

_____

8. Notes:

Who provide health history? _____ Date:_____

Reviewed by RN:_____ Date:_____