Family Food Allergy Health History Form

Student Name: _____ Date of Birth: _____
Parent/Guardian: _____ Today's Date: _____
Home Phone: _____ Work: _____ Cell: _____
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	❑ 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 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. 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 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	
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 what foods to avoid ❑ No ❑ Yes
   2. Ask about food ingredients ❑ No ❑ Yes
   3. Read and understands 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 refuses 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? _____

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
   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:** _____

Reviewed by R.N.: _____ **Date:** _____

Adapted with permission – Washington State Guidelines for Anaphylaxis