

SEVERE ALLERGY HEALTH HISTORY

Student Name: _____ School Year: _____

Date of Birth: _____ Teacher/ Team/ Grade: _____

1) Allergic to:

- | | | |
|--|---|---------------------------------------|
| ☐ Peanuts Only (May eat tree nuts: YES NO) | ☐ Milk/ Dairy (baked/cooked OK YES/NO) | ☐ Soy |
| ☐ Tree Nuts like almonds, walnuts, pecans (May eat peanuts: YES NO) | ☐ Egg (baked/cooked OK YES/NO) | ☐ Wheat |
| | ☐ Fish/ Shellfish | ☐ Bee/Wasp |
| | | ☐ Latex |
| | | ☐ Other: _____ |

I give my child responsibility for choosing food items they purchase from the cafeteria

- ☐
- Yes
- ☐
- No

I will contact the cafeteria manager because my child requires special alerts/restrictions

- ☐
- Yes
- ☐
- No

2) Severity of Allergy (Circle One)

(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

3) Symptoms (please circle all symptoms your child has experienced in the past)

<i>Skin:</i>	Hives	Itching	Rash	Flushing	Swelling (face, hands, arms, legs)
<i>Mouth:</i>	Itching	Swelling (lips, tongue, mouth)			
<i>Abdomen:</i>	Nausea	Cramps	Vomiting	Diarrhea	
<i>Throat:</i>	Itching	Tightness	Cough	Hoarseness	
<i>Lungs:</i>	Wheezing	Shortness of breath		Repetitive cough	
<i>Heart:</i>	Weak pulse	Loss of consciousness			

Comments/ Other: _____

4) Able/ willing to communicate their symptoms to an adult

- ☐
- Yes
- ☐
- No

5) Treatment options:

- | | | |
|---|--|---|
| ☐ No treatment required | ☐ Nebulizer (breathing) treatment | ☐ EpiPen (Epinephrine) |
| ☐ Antihistamine (Benadryl) | ☐ Inhaler | ☐ Other |

6) Other Health Concerns (circle one):

Asthma: YES NO

Other: YES NO If YES, please list: _____

My Child has permission to transport his/her medication back home when no longer needed in the clinic/ at the end of the school year (circle): YES NO

By signing this form, I authorize permission for this information to be shared with any school personnel who would be responsible for my child during the school day.

Printed Name: _____ Phone Number: _____

Signature: _____ Date: _____

Student Name: _____ DOB: _____

Teacher/ Team/ Grade: _____

ALLERGY TO:

- | | | |
|---|-------------------------------------|---------------------------------------|
| ☐ PEANUT | ☐ MILK/DAIRY | ☐ LATEX |
| ☐ TREE NUT | ☐ EGG | ☐ OTHER: _____ |
| ☐ FISH/SHELLFISH | ☐ SOY | |
| ☐ WHEAT | ☐ BEE/WASP | |

Asthma: _____YES _____NO

**This student can safely eat in the cafeteria: _____YES _____NO

**For this student's health/safety, eating at an allergy safe table is: _____MANDATORY _____Not Required

One or more SEVERE symptoms	INJECT EPINEPHRINE IMMEDIATELY
Lung: Short of breath, wheezing, repetitive cough Heart: Pale, blue, faint, weak pulse, dizzy, confused Throat: Tight, hoarse, trouble breathing/swallowing Mouth: Obstructive swelling (tongue or lips) Skin: Many hives over body Gut: Vomiting, diarrhea, cramping pain OR COMBINATION of symptoms from different body areas.	1. Call 911 after injecting with Epinephrine 2. Begin monitoring (see below) 3. Give additional medications: Antihistamines, Inhaler (bronchodilator) *Antihistamines & bronchodilators are not to be depended upon alone to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS	GIVE ANTIHISTAMINE
Mouth: Itchy mouth Skin: A few hives around mouth/face or mild itch Gut: Mild nausea/discomfort	1. Stay with Student; call parent and/or physician 2. If symptoms progress, inject Epinephrine 3. Begin monitoring student (see below)

MONITORING THE STUDENT: stay with the student, contact the parent and call 911 to notify epinephrine was given and the time given. Treat student even if parent cannot be reached. Keep student lying on back with lower legs/feet elevated.

**This student is extremely reactive to the above allergens; give epinephrine IMMEDIATELY if allergen was likely OR definitely eaten, EVEN IF NO SYMPTOMS ARE NOTED. _____YES _____NO MD Initials: _____

Medications:

Epinephrine (brand & dose): _____

Antihistamine (brand & dose): _____

Other (inhaler/bronchodilator if asthmatic): _____

**This student may carry epinephrine or inhaler while at school: _____YES _____NO

As a healthcare provider licensed in the State of Indiana, I have reviewed the orders above with the patient's parent/guardian and they understand the orders as written.

Physician Signature/ Printed: _____ DATE: _____

As parent of above student, I understand and agree to HSE's school policy/procedure that states if epinephrine is given, 911 will be called and the student will be transported to the emergency room for evaluation. By signing this form, I authorize permission for any of the above information to be shared with any school personnel who would be responsible for my child during the school day.

Printed Name: _____ Phone Number: _____

Signature: _____ Date: _____

