Tidehaven Independent School District

47 CR 427 Doman Road P.O. Box 129 El Maton, TX 77440-0129 www.tidehavenisd.com

ALLERGY/ANAPHYLAXIS HISTORY

Student's Name_____ DOB_____Grade_____
Primary Healthcare Provider_____ Phone_____
Allergist _____Phone_____

Does your child have a Section 504 Plan for this health condition? Yes____ No____

Has a healthcare provider diagnosed your child with severe allergies? Yes____ No____

Are your child's allergies life-threatening? Yes____ No____

Has your child required an emergency room visit or hospitalization due to allergies/anaphylaxis? Yes____ No____
If YES, explain
_____
_____

What is your child allergic to? (Check all that apply)

- o Peanuts
- o Tree nuts
- o Eggs
- o Milk
- o Soy
- o Fish/Shellfish
- o Latex
- o Insect stings
- o Medication, list medications _____
- o Other, describe _____

Has your child been prescribed medication for the treatment of allergies, including emergency medications? Yes____ No____

List all medications prescribed for your child:

Medication Name	Dosage	Frequency	Will this medication be given at school? Yes/No

Tidehaven Independent School District

47 CR 427 Doman Road P.O. Box 129 El Maton, TX 77440-0129 www.tidehavenisd.com

How many times has your child had a reaction? _____

When was your child's last reaction? _____

What are the early signs of your child's reaction? _____

Please circle ALL symptoms 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	
Lungs:	Shortness of breath				
Heart:	Weak pulse	Loss of consciousness			

Has your child ever received "allergy shots"? Yes____ No____, If YES, when_____

What is your child's self-care level for his/her allergies at school?

- o Independent management
- o Assistance from staff
- o Complete care from staff

How does your child communicate his/her symptoms? _____

Does your child:

- Know how to prevent his/her own exposure? Yes___ No____
- Know what foods/medications to avoid? Yes___ No____
- Ask about food ingredients? Yes___ No____
- Read and understand food/medication labels? Yes___ No____
- Tell an adult immediately after an exposure? Yes___ No____
- Firmly refuse a problem food/medicine? Yes___ No____
- Know how to use emergency medication? Yes___ No____

Parent/Guardian Name: _____Date: _____

Parent/Guardian Signature: _____

Reviewed by Nurse: _____ Date: _____