



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)

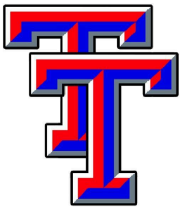
- ☐ Peanuts
- ☐ Tree nuts
- ☐ Eggs
- ☐ Milk
- ☐ Soy
- ☐ Fish/Shellfish
- ☐ Latex
- ☐ Insect stings
- ☐ Medication, list medications _____
- ☐ Other, describe _____

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





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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?

- ☐ Independent management
- ☐ Assistance from staff
- ☐ 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: _____

