



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? <table><tr><td>☐ Peanuts</td><td>☐ Insect Stings</td></tr><tr><td>☐ Eggs</td><td>☐ Fish/Shellfish</td></tr><tr><td>☐ Milk</td><td>☐ Chemicals _____</td></tr><tr><td>☐ Latex</td><td>☐ Vapors _____</td></tr><tr><td>☐ Soy</td><td>☐ Tree Nuts (walnuts, pecans, etc.)</td></tr><tr><td>☐ Other: _____</td><td></td></tr></table>	☐ 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
☐ Peanuts	☐ Insect Stings												
☐ Eggs	☐ Fish/Shellfish												
☐ Milk	☐ Chemicals _____												
☐ Latex	☐ Vapors _____												
☐ Soy	☐ Tree Nuts (walnuts, pecans, etc.)												
☐ Other: _____													

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: _____