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/ShelIfish  □ 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