National Association of School Nurses

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/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

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:

Mouth: ☐ Itching ☐ Swelling lips ☐ Swelling mouth ... arms, hands, legs

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

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