WFISD

Department of School Health Services

Family Allergy Health History Form

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____Today's Date: _____

Parent Phone: Home: _____ Work: _____ Cell: _____ Email: _____

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 ❒ Soy ❒ Vapors _____

❒ Eggs ❒ Insect Stings

❒ Milk ❒ Fish/Shellfish

❒ Latex ❒ Chemicals _____

❒ 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 the 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 or other allergen(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(s)? ❒ 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. Wears 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 severe 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 severe allergy? _____

7. General Health

a. How is your child's general health other than having a severe 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. Is there anything else you would like the school to know about your child's health: _____
   _____

8. Notes:

_____

_____

_____

_____

Parent / Guardian Signature: _____ Date: _____

Reviewed by RN: _____ Date: _____