**Allergy History** **STUDENT NAME_____ DATE _____**

The following form will assist the school nurse and staff in determining any special needs for your child and the development of an individualized healthcare plan (IHP). This form is to be completed at initial IHP development and every 2 years thereafter. If you desire a conference with the school nurse, please call your child's school for an appointment.

1. **Does your child have a diagnosis of an allergy from a healthcare provider:** ☐ **No** ☐ **Yes**

   Allergist:_____ Phone:_____

2. **History of Current Status:**

   a)

   b) What is your child allergic to:

   ☐ Peanuts ☐ Tree Nuts:_____
   ☐ Eggs ☐ Fish/Shellfish
   ☐ Milk ☐ Chemicals:_____
   ☐ Latex ☐ Vapors:_____
   ☐ Soy ☐ Insects: _____
   ☐ Other: _____

   c) How many times has the child had a reaction

   ☐ Never ☐ Once ☐ More than once

   d) Explain their past reactions: _____

   _____

   Date of last reaction:_____

   e) Are the reactions: ☐ Same ☐ Better ☐ Worse

   c) Age of child when allergy was first discovered:_____

3. **Trigger and Symptoms:**

   a. What are the early signs and symptoms of your child's allergic reaction? (Be specific; include things the child might say): _____

   b. How does your child communicate his/her symptoms? _____

   c. How quickly do symptoms appear after exposure? Within: _____ secs ____ mins _____ hrs ____ days

   d. Please check the symptoms your child has experienced in the past:

| Skin | Mouth | Abdominal (Stomach) | Throat | Lungs | Heart |
|---|---|---|---|---|---|
| ☐ **Hives** | ☐ **Itching** | ☐ **Nausea** | ☐ **Itching** | ☐ **Shortness of Breath** | ☐ **Weak pulse** |
| ☐ **Itching** | ☐ **Swelling (lips, tongue, mouth)** | ☐ **Cramps** | ☐ **Tightness** | ☐ **Repetitive cough** | ☐ **Loss of consciousness** |
| ☐ **Rash** | | ☐ **Vomiting** | ☐ **Hoarseness** | | |
| ☐ **Flushing** | | ☐ **Diarrhea** | ☐ **Cough** | | |
| ☐ **Swelling (face, arms, hands, legs)** | | | | | |

4. **Treatment:**

   a. How have past reactions been treated? _____

   b. How effective was the child's response to treatment? _____

   c. Was there an emergency room visit? ☐ No ☐ Yes, explain:_____

   d. Was the child 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:

   _____

**Continued on reverse

**5. Self-Care:**

a. Is your child able to monitor and prevent their own exposure? ☐ No ☐ Yes

b. b. Does your child:

i. Know what foods to avoid……..... ☐ No ☐ Yes

ii. Ask about food ingredients……..... ☐ No ☐ Yes

iii. Read and understand food labels……..... ☐ No ☐ Yes

iv. Tell an adult immediately after an exposure……☐ No ☐ Yes

v. Wear a medical alert bracelet, necklace, watchband…… ☐ No ☐ Yes

vi. Tell peers and adults about the allergy…… ☐ No ☐ Yes

vii. Firmly refuse a problem food……..☐ No ☐ Yes

c. Does you child know how to use their emergency medication? ☐ No ☐ Yes

d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

**6. Family/Home**

a. Does your child carry epinephrine in the event of a reaction? ☐ No ☐ Yes

b. Has your child ever needed to administer that epinephrine? ☐ No ☐ Yes

c. Do you feel that your child needs assistance in coping with his/her food allergy? ☐ No ☐ Yes

**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? ____ If yes, does he/she have an Asthma Action Plan? ____

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:** _____ **Date:** _____