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
- ❑ Eggs
- ❑ Milk
- ❑ Latex
- ❑ Soy
- ❑ Other: __________
- ❑ Insect Stings
- ❑ Fish/Shellfish
- ❑ Chemicals
- ❑ Vapors
- ❑ Tree Nuts (walnuts, pecans, etc.)

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: ____________

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8. Notes:

Parent / Guardian Signature: ____________________ Date: ____________

Reviewed by R.N.: ____________________ Date: ____________

Adapted with permission – Washington State Guidelines for Anaphylaxis