School District of Springfield Township
Allergy Health History Form

Student Name:_____ Date of Birth: _____

Parent/Guardian: _____Preferred daytime phone number: _____

Parent/Guardian: _____Preferred daytime phone number: _____

Primary Healthcare Provider: _____ Phone: _____

Allergist: _____ Phone: _____

Does your child have a diagnosis of an allergy from a healthcare provider: ❑ No ❑ Yes

History and Current Status

1. Please list any food/environmental items to which your child is allergic or severely allergic, as well as the route of exposure, reaction, and if you consider the reaction "life threatening" or "mild".

Food/Insect/Environmental Agent or Medication	***Route of exposure: Eaten, Touched, Inhaled***	***Symptoms of Allergic Reaction***	***Life Threatening or Mild Reaction***
example: *Latex Allergy*	*reaction occurs when touches latex*	*itchy skin*	*mild*

2. Age of student when allergy first discovered:_____

3. How many times has student had a reaction?
   ❑ Never ❑ Once ❑ More than once, explain: _____
4. Explain his/her past reaction(s): _____
   _____

Trigger and Symptoms

1. What are the early signs and symptoms of your child's allergic reaction? *(Be specific; include things the student might say.)*
   _____
   _____
2. How does your child communicate his/her symptoms?
   _____
3. How quickly do symptoms appear after exposure to allergen(s)? ____ secs. ____mins. ____hrs. ____days
4. 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			

Treatment

1. How have past reactions been treated? _____
2. How effective was your child's response to treatment? _____
3. Was there an emergency room visit? ❑ No ❑ Yes, explain: _____
4. Was he/she admitted to the hospital? ❑ No ❑ Yes, explain: _____
5. What treatment or medication has your healthcare provider recommended for use in an allergic reaction?

   _____
6. Has your healthcare provider provided you with a prescription for medication? ❑ No ❑ Yes
7. Have you used the treatment or medication? ❑ No ❑ Yes
8. If so, please describe any side effects or problems your child had in using the suggested treatment:

   _____

Self -Care

1. Does your child:

Know what foods to avoid	❑ No	❑ Yes
Ask about food ingredients	❑ No	❑ Yes
Read and understand food labels	❑ No	❑ Yes
Tell an adult immediately after a possible exposure	❑ No	❑ Yes
Wear a medical alert bracelet, necklace, watchband	❑ No	❑ Yes
Tell peers and adults about the allergy	❑ No	❑ Yes
Firmly refuse a problem food	❑ No	❑ Yes

3. Does your child know how to use his/her emergency medication? ❑ No ❑ Yes
4. Has your child ever administered their own emergency medication? ❑ No ❑ Yes

General Health

1. Does your child have other health conditions? _____
2. Has your child had previous hospitalizations?

   _____
3. Does your child have a history of asthma? ❑ No ❑ Yes
4. If yes, does he/she have an Asthma Action Plan? ❑ No ❑ Yes
5. Please add anything else you would like the school to know about your child's health:

   _____

Individual Considerations Regarding Food Allergies at School:

1. Does your child require special seating at the Allergy Aware table in the cafeteria (If allergic to more than one food, please be specific for each individual food.) **(Please list the food names below)**
   Food name:_____ ❑ No ❑ Yes
   Food name:_____ ❑ No ❑ Yes
   Food name:_____ ❑ No ❑ Yes
   Food name:_____ ❑ No ❑ Yes
2. Food which may be eaten in school (including lunch and snacks):
   - ❑ must only be provided by me
   - ❑ may be given to my child by school staff only with my prior approval
   - ❑ the following foods may be given to my child by school staff without my specific approval*:

     _____
   - ❑ my child is able to independently choose which foods (s)he can eat or not eat

*A conference with the teacher regarding classroom snacks and in class lessons involving food is **highly** recommended**.**

3. For students with anaphylactic or potentially life threatening food allergies documented by a health care provider, would you like your child's classmates and their parents to be notified of your child's allergy? (If yes, a letter will be sent home at the beginning of each school year requesting that no classroom snacks, birthday treats or party items containing/possibly containing the food allergen be sent into school.)

   ❑ No ❑ Yes, please send a letter.

4. Transportation:

   ❑ My child will carry his/her emergency medication on the bus daily. (Student may carry emergency medications with special permissions, please check with your school nurse.)

   ❑ My child will not carry his/her medication daily on the bus.

   ❑ My child does not ride the bus.

5. If your child attends school sponsored extracurricular activities, please notify the school nurse and/or the adult in charge of the activity.

Is there anything else you would like us to know to help assist your child at school:

_____

_____

If your child will need to have epinephrine and/or an antihistamine available in school, please:

- Submit the medication(s) in the original container from the pharmacy.
- Provide written permission(s) from both the parent and the doctor for each medication (even if the medication is an over-the-counter medication). Medication administration consent forms can be downloaded from the district website or you may request them from your child's school nurse's office.

Please return all these items to your child's school nurse on or before the first day of school. Thank you.

Thank you for providing this information to help us provide the best care we can for your child. This information and your child's picture may be shared with school personnel who work directly with your child and when deemed necessary for your child's educational experience.

Please sign and return this form to your child's school nurse.

Parent / Guardian Signature: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____