SAMPLE SEVERE ALLERGY HEALTH HISTORY INTAKE FORM

Student name: ______________________ Date of Birth: __________ Today's Date: ______________

Parent(s)/Guardian: ____

Home Phone: ______________ Work: ________________ Cell: ________________

Primary Healthcare Provider: __________________________ Phone: ______________

Allergist: ____ Phone: ______________

Does your child/youth have a diagnosis of an allergy from a healthcare provider? ☐ Yes ☐ No

Type of Food Allergy

☐ IgE response (characterized by the rapid onset of symptoms following ingestion)

☐ Non-IgE response (typically affects the gastrointestinal tract, which can result in a chronic inflammation of the gut; common acute symptoms include vomiting, diarrhea, and abdominal cramping)

What is your child/youth allergic to?

☐ Milk ☐ Peanuts ☐ Eggs ☐ Tree nuts ☐ Fish

☐ Shellfish/crustaceans ☐ Wheat ☐ Soy ☐ Sesame

Other food(s) ____

☐ Insect stings (what type) ______________________________________

☐ Latex ☐ Chemicals (list) ______________________________________

☐ Medication or vaccine (list) ___________________________________

Age of child/youth when allergy was first discovered: ______ Number of times child/youth had a reaction: ______

What are the early signs and symptoms of your child/youth's allergic reaction? ______________

____

How might your child/youth communicate symptoms? ______________________

How quickly have symptoms appeared after exposure to food(s)?

☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Never had a reaction

Please check the symptoms that your child/youth has experienced in the past:

Skin: ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling (face, arms, hands, legs)

Mouth: ☐ Itching ☐ Swelling (lips, tongue, mouth)

Gut: ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea

Throat: ☐ Itching ☐ Tightness ☐ Hoarseness ☐ Cough ☐ Trouble Swallowing

Lungs: ☐ Shortness of Breath ☐ Repetitive Cough ☐ Wheezing

Heart: ☐ Weak pulse ☐ Loss of consciousness ☐ Dizziness/fainting

Neurologic: ☐ Sense of impending doom ☐ Irritability/change in mood ☐ Change in alertness ☐ Confusion

☐ Other: ____

☐ Symptoms unknown, avoidance of food for testing

How have reactions been treated in the past? ______________________________

Has 911/EMS ever been called? ☐ Yes ☐ No

Has your child/youth ever been treated in an ER? ☐ Yes ☐ No

Does your child/youth have a food allergy action plan or emergency care plan from their medical provider?

☐ Yes ☐ No

Has your child/youth been prescribed an epinephrine auto-injector to treat an allergic/anaphylactic reaction?

☐ Yes ☐ No

Food Allergy – Does your child/youth know:

- What food(s) to avoid ☐ Yes ☐ No
- To refuse a food that may be a problem ☐ Yes ☐ No
- To ask about food ingredients ☐ Yes ☐ No
- How to read and understand food labels ☐ Yes ☐ No
- To tell an adult if they may have had an exposure ☐ Yes ☐ No
- To wear a medical alert bracelet, necklace, or watchband ☐ Yes ☐ No
- How to reach a parent/guardian in an emergency ☐ Yes ☐ No

Has your child/youth been evaluated by their medical provider for readiness and competency to self-carry and administer their emergency medication? ☐ Yes ☐ No

Has your child/youth ever administered their own emergency medication? ☐ Yes ☐ No

Do you have concerns about how your family is coping with your child/youth's food allergy? ☐ Yes ☐ No

Would you like to discuss any concerns with the school nurse? ☐ Yes ☐ No

Does your child/youth have asthma? ☐ Yes ☐ No

What medication has been prescribed for your child/youth's asthma? ______________________________

Does your child/youth have an asthma action plan or emergency care plan from their medical provider?

☐ Yes ☐ No

Does your child/youth have any other health conditions? ______________________________

Parent/Guardian Signature: ______________________________ Date: ______________

Reviewed by Registered Nurse: ______________________________ Date: ______________