ST JUDE REGIONAL CATHOLIC SCHOOL

Cynthia Richter, RN **School Year: _____-_____**

STUDENT FOOD ALLERGY 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 ___ Insect Stings
___ Eggs ___ Fish/Shellfish
___ Milk ___ Chemicals _____
___ Latex ___ Vapors _____
___ Soy ___ Tree Nuts (walnuts, pecans, etc.)
___ Other: _____

b. Age of your child when allergy first discovered: _____
c. How many times has your child 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 child'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 your child's response to treatment? _____
c. Was there an emergency room visit? ___ No ___ Yes, explain: _____
d. Was your 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 send 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 exposure?	___ No	___ Yes
b. Does your child:		
1. Know what foods to avoid	___ No	___ Yes
2. Ask about food ingredients	___ No	___ Yes
3. Read and understands food label	___ 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 child'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 condition?

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: _____

_____

8. Notes:

Parent/Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____