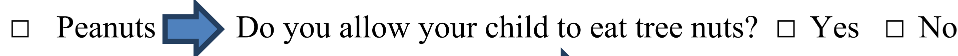
Hamilton Southeastern Schools **PARENT FOOD ALLERGY HEALTH HISTORY FORM**

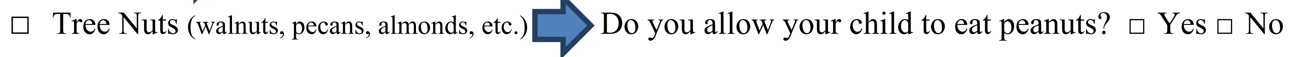
Student Name:____Date of Birth:__________________
Today's Date:__________________School Year:___________________Teacher/Grade__________________
Parent/Guardian:________________________________ / ______________________________________
Phone #'s: (c)______________ (w)_______________ / (c)______________ (w)_________________
Home #:____ Contact Comments:_________________________
Other Emergency Contacts:
Name / Relationship:____Phone #:______________________
Name / Relationship:____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 ➡ Do you allow your child to eat tree nuts? ☐ Yes ☐ No



☐ Tree Nuts (walnuts, pecans, almonds, etc.) ➡ Do you allow your child to eat peanuts? ☐ Yes ☐ No

☐ Milk/Dairy____________________________ ☐ Fish/Shellfish ☐ Soy ☐ Wheat

☐ Egg____

☐ Other____

Comments____

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 how their past reaction(s) occurred_________________________________
____
____
____

3. Symptoms:

a. What are the early signs & symptoms of your student's allergic reaction? (Be specific; include what your child might say)____
____

b. Please check all of the symptoms that your child has experienced in the past with an allergic reaction:

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

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

Abdomen: ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea

Throat: ☐ Itching ☐ Tightness ☐ Cough ☐ Hoarseness

Lungs: ☐ Wheezing ☐ Shortness of breath ☐ Repetitive cough

Heart: ☐ Weak pulse ☐ Loss of consciousness

Comments____

c. Will your child communicate their symptoms to an adult? ☐ Yes ☐ No
____

d. How quickly do symptoms appear after exposure to their food allergen? ___secs. ___mins. ___hrs.
____

4. Treatment:

a. How have past reactions been treated?

☐ No treatment required ☐ Antihistamine (Benadryl) ☐ Nebulizer (breathing) treatment

☐ Inhaler ☐ Epipen (Epinephrine) ☐ Other_______________

b. How effective was your child's response to treatment?_______________

c. Have you had to seek emergency room treatment for a reaction? ☐ Yes ☐ No If yes, please explain_______________

d. Has your child ever been admitted to the hospital for an allergic reaction? ☐ Yes ☐ No
If yes, please explain_______________

e. What treatment or medication has your physician recommended for use in an allergic reaction?

____

____

5. Student Knowledge & 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 & understand food labels	☐ NO	☐ YES
4. Tell an adult immediately after an exposure	☐ NO	☐ YES
5. Recognize signs of an allergic reaction	☐ NO	☐ YES
6. Know not to trade or take food from classmates	☐ NO	☐ YES
7. Wear a medical alert bracelet/necklace identifying allergy	☐ NO	☐ YES
8. Tell peers & adults about the allergy	☐ NO	☐ YES
9. Refuse they have a problem food	☐ NO	☐ YES
c. Does your child know how to use their prescribed emergency medication?	☐ NO	☐ YES
d. Has your child ever administered their own emergency medication?	☐ NO	☐ YES
e. Does your child carry Epinephrine (Epipen) with them or in their backpack?	☐ NO	☐ YES

6. Other Health Concerns:

a. Does your child have asthma? ☐ NO ☐ YES

b. Does your child have other health conditions? ☐ NO ☐ YES If yes, please list_______________

____

c. List medications your child takes daily or as needed at home:_______________

____

Thank you for your time and assistance in assessing your child's special needs at school. By signing this form, you authorize permission for this information to be shared with any school personnel who would be responsible for your child during the school day.

Parent / Guardian Signature:_______________Date:_______________

My student has permission to transport his/her medication back home when no longer needed in the clinic or at the end of the school year: ☐ NO ☐ YES

Parent / Guardian Signature:_______________

Reviewed by R.N.:_______________Date:_______________