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

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: __________________

____

8. Notes:

Parent / Guardian Signature: ____ **Date:** ______________

Reviewed by R.N.: ____ **Date:** ______________

Adapted with permission – Washington State Guidelines for Anaphylaxis

American Academy of Allergy Asthma & Immunology
www.aaaai.org

Anaphylaxis Emergency Action Plan

Patient Name: ______________________________ **Age:** __________

Allergies: ______________________________

Asthma ☐ **Yes** ***(high risk for severe reaction)*** ☐ **No**

Additional health problems besides anaphylaxis: ______________________________

____

Concurrent medications: ______________________________

____

Symptoms of Anaphylaxis

MOUTH	**itching, swelling of lips and/or tongue**
THROAT*	**itching, tightness/closure, hoarseness**
SKIN	**itching, hives, redness, swelling**
GUT	**vomiting, diarrhea, cramps**
LUNG*	**shortness of breath, cough, wheeze**
HEART*	**weak pulse, dizziness, passing out**

Only a few symptoms may be present. Severity of symptoms can change quickly.
****Some symptoms can be life-threatening. ACT FAST!***

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):

☐ **Adrenaclick (0.15 mg)** ☐ **Adrenaclick (0.3 mg)**

☐ **Auvi-Q (0.15 mg)** ☐ **Auvi-Q (0.3 mg)**

☐ **EpiPen Jr (0.15 mg)** ☐ **EpiPen (0.3 mg)**

Epinephrine Injection, USP Auto-injector- authorized generic
☐ **(0.15 mg)** ☐ **(0.3 mg)**

☐ **Other (0.15 mg)** ☐ **Other (0.3 mg)**

Specify others: ______________________________

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

2. Call 911 or rescue squad (before calling contact)

3. Emergency contact #1: home__________ **work**__________ **cell**__________

Emergency contact #2: home__________ **work**__________ **cell**__________

Emergency contact #3: home__________ **work**__________ **cell**__________

Comments: ______________________________

____

____
Doctor's Signature/Date/Phone Number

____
Parent's Signature (for individuals under age 18 yrs)/Date

This information is for general purposes and is not intended to replace the advice of a qualified health professional. For more information, visit www.aaaai.org. © 2013 American Academy of Allergy, Asthma & Immunology 7/2013