



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

Form with two columns of questions: a. What is your child allergic to? b. Age of student when allergy first discovered? c. How many times has student had a reaction? 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)?
d. Please check the symptoms that your child has experienced in the past: Skin, Mouth, Abdominal, Throat, Lungs, Heart

4. Treatment

Form with questions: a. How have past reactions been treated? b. How effective was the student's response to treatment? c. Was there an emergency room visit? d. Was the student admitted to the hospital? 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? g. Have you used the treatment or medication? 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: _____