



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 boxes containing questions about allergies: 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)? ___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
Heart: [] Weak pulse [] Loss of consciousness [] Wheezing

4. Treatment

Form with questions about 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? 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Does your student:		
1. Know what foods to avoid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Ask about food ingredients	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3. Read and understands food labels	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4. Tell an adult immediately after an exposure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Wear a medical alert bracelet, necklace, watchband	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6. Tell peers and adults about the allergy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7. Firmly refuses a problem food	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Does your child know how to use emergency medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes _____
d. Has your child ever administered their own emergency medication?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
c. Has your child ever needed to administer that epinephrine?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, does he/she have an Asthma Action Plan?	<input type="checkbox"/> No <input type="checkbox"/> 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