HEALTH SERVICES
Center Grove Community School Corporation

Life Threatening 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): _____
_____

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 allergen(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 did he/she respond to this 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 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 child able to monitor and prevent their own exposures? ❑No ❑Yes

b. Does your child:

1. Know what allergens to avoid? ❑No ❑Yes
2. Ask about food ingredients (if food allergy)? ❑No ❑Yes
3. Read and understand food labels (if food allergy)? ❑No ❑Yes
4. Tell an adult immediately after an exposure? ❑No ❑Yes
5. Wear a medical alert bracelet, necklace or watchband? ❑No ❑Yes
6. Tell peers and adults about the allergy? ❑No ❑Yes
7. Firmly refuse a problem situation involving an allergen? ❑No ❑Yes

c. Does your child know how to use emergency medication? ❑No ❑Yes

d. Does your child carry epinephrine in the event of a reaction? ❑No ❑Yes

e. Has your child ever needed to administer that epinephrine? ❑No ❑Yes

6. General Health

a. How is your child's general health other than having a life threatening 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: _____

_____

_____

_____

7. School Meals and Snacks (for Food Allergies only)

a. Will your child be purchasing lunch at school? ❑Never ❑Always ❑Sometimes

b. Will your child be purchasing breakfast at school? ❑Never ❑Always ❑Sometimes

c. Does your child need to sit at a designated allergen-free table in the cafeteria? ❑No ❑Yes

d. I will provide ALL food for my child to eat as classroom snacks and treats. ❑No ❑Yes

e. Additional Comments: _____

_____

_____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____