Humble Independent School District Health Services

Allergy Health History

Student Name:_____

Student ID:_____ Date of Birth: _____

Parent/Guardian:_____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ☐ **No** ☐ **Yes**

Allergist:_____ Phone:_____

2. History of Current Status:

a. What is your child allergic to:

- ☐ Peanuts
- ☐ Eggs
- ☐ Milk
- ☐ Latex
- ☐ Soy
- ☐ Other: _____
- ☐ Tree Nuts _____
- ☐ Fish/Shellfish
- ☐ Chemicals_____
- ☐ Vapors _____
- ☐ Insects _____

b. Age of student when allergy first discovered:_____

c. How many times has the student had a reaction:
☐ Never ☐ Once ☐ More than once

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? Within: _____ secs _____ mins _____ hrs _____ days

d. Please check the symptoms your child has experienced in the past:

Skin	Mouth	Abdominal	Throat	Lungs	Heart
☐ Hives	☐ Itching	☐ Nausea	☐ Itching	☐ Shortness of breath	☐ Weak pulse
☐ Itching	☐ Swelling (lips, tongue, mouth)	☐ Cramps	☐ Tightness	☐ Repetitive Cough	☐ Loss of Consciousness
☐ Rash		☐ Vomiting	☐ Hoarseness	☐ Wheezing	
☐ Flushing		☐ Diarrhea	☐ Cough		
☐ Swelling (face, arms, hands, legs)					

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 exposure? ☐ No ☐ Yes
b. Does your student:
   1. Know what foods to avoid……..... ☐ No ☐ Yes
   2. Ask about food ingredients……..... ☐ No ☐ Yes
   3. Read and understand 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 refuse a problem food……..☐ No ☐ Yes

c. Does you student know how to use their 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? ☐ No ☐ Yes

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? ____ If yes, does he/she have an Asthma Action Plan? ____
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:_____ **Campus:**_____ **Date:** _____