Shorecrest | Be More

Shorecrest Preparatory School
Severe 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 ☐ Tree Nuts
☐ Soy ☐ Latex

☐ 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 allergy reactions:
☐ Same ☐ Better ☐ Worse

3. Trigger and Symptoms

a. Which route(s) trigger a reaction? ☐ Ingestion ☐ Contact ☐ Inhalation
b. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say).* _____
_____
c. How does your child communicate his/her symptoms? _____
d. How quickly do symptoms appear after exposure to the allergen? ___ secs. ___ mins. ___ hrs. ___ days
e. 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	☐ Cough	☐ Hoarseness	
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 given you a prescription for medication? ☐ No ☐ Yes
g. Have you ever 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 (if applicable) ☐ No ☐ Yes
2. Ask about food ingredients (if applicable) ☐ No ☐ Yes
3. Read and understand food labels (if applicable) ☐ 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 (if applicable) ☐ No ☐ Yes

c. Does your child 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 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 allergy? _____

7. General Health

a. How is your child's general health other than having an allergy? _____

b. Does your child have other health conditions? _____

c. Has your child had any 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. Food at School (fill out if applicable)

a. How will your child receive food at school? ☐ Packed from home ☐ School dining room

b. Do you want your child at an allergen-free table during lunch? ☐ No ☐ Yes

c. Do you plan to provide safe snack items for your child in the event of a classroom party? ☐ No ☐ Yes

If no, describe how you would like classroom parties addressed: _____

_____

8. Notes: ***(RN use only)***

Parent / Guardian Signature: _____ **Date:** _____

Reviewed by RN: _____ **Date:** _____