



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

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):
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 [] 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 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 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: _____