ALLERGY HISTORY

Please, complete this form and return it to the school nurse. Thank you for helping us keep your child safe and healthy at school.

Please list what your child is allergic to (include all foods, insects, medications, environmental, and latex):

1. What kind of reaction has your child had to the above listed allergen(s) in the past (note: each reaction can present with different symptoms)?

☐ Hives ☐ Rash ☐ Itching ☐ Vomiting ☐ Swelling ☐ Hard to breathe ☐ Wheezing

☐ Other? _____

2. When was the last time your child had an allergic reaction? _____

3. Did you use an epinephrine auto-injector in this reaction? ☐ Yes ☐ No

4. Have you ever used an epinephrine auto-injector for your child's allergic reaction? ☐ Yes ☐ No

If yes, when? _____

5. Does your child require an epinephrine auto-injector or any additional medication at school to keep them safe with allergies? ☐ Yes ☐ No

(If yes, please complete and return the medication authorization form.)

6. When was your child's last doctor visit for the above listed allergy(ies) and what suggestions did he/she give if a reaction occurs?

7. Did you receive a Emergency Care Plan (ECP)/Food Allergy Action Plan (FAAP) from your child's doctor? ☐ Yes ☐ No

8. Does your child require special diet restrictions from the school cafeteria? ☐ Yes ☐ No

(If yes, please complete and return the Medical Statement for Special Meals.)

Healthcare provider/allergist name _____ **Phone** _____

Parent/guardian name _____

_____

PARENT/GUARDIAN SIGNATURE DATE