LAMPASAS INDEPENDENT SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
207 W. 8TH STREET
LAMPASAS, TX 76550

FOOD AND OTHER ALLERGIES HEALTH HISTORY FORM

Student Name: _____ DOB: _____ Grade/Campus: _____

Parent/Guardian Name: _____ Today's Date: _____

Cell #: _____ Work #: _____

Primary Healthcare Provider: _____

1. **Does your child have a diagnosis of an allergy from a healthcare provider?** ☐ YES ☐ NO
2. **Will your child have at school:** ☐ Epinephrine Pen ☐ Benadryl ☐ NO emergency allergy medication
3. **History and Current Status:**

a) What is your child allergic to?

Food Allergies **(must mark **d)**

- ☐ Peanuts
- ☐ Tree Nuts (walnuts, pecans, etc)
- ☐ Milk
- ☐ Fish / Shellfish
- ☐ Eggs
- ☐ Other: _____

Environmental

- ☐ Latex
- ☐ Insect Bites
- ☐ Chemicals
- ☐ Vapors

b) Age when allergy first discovered:

c) How many times has student had reaction?

☐ Never ☐ Once ☐ More than once

** **d) Is the food allergy:**

- ☐ Ingested Only
- ☐ Inhalation (must have a doctor's note)
- ☐ Contact

4. **Signs and Symptoms:**
   a) What are the early signs and symptoms of your student's allergic reaction? (be specific / include things the student might say or do)

   _____

   _____

   b) How quickly do symptoms appear after exposure to allergen? ☐ seconds ☐ minutes ☐ hours ☐ days

   c) Please check all symptoms your child has experienced in the past with this allergy:

   ☐ throat tightening ☐ throat itching ☐ hoarseness ☐ coughing
   ☐ chest tightening ☐ weak pulse ☐ wheezing ☐ shortness of breath
   ☐ skin itching ☐ rash / hives ☐ flushed skin ☐ loss of consciousness
   ☐ nausea ☐ vomiting ☐ diarrhea ☐ abdominal cramps
   ☐ swelling at exposure site ☐ swelling of lips/mouth/tongue/face/throat

5. **Treatment**
   a) Was there an emergency room visit in previous exposures? ☐ YES ☐ NO
   b) What treatment or medication has your healthcare provider recommended for use in an allergic reaction?
   Medication: _____ Other: _____
   c) Are you providing this treatment to the school? ☐ YES ☐ NO
   d) Has your child received this treatment before? ☐ YES ☐ NO
   e) Please describe any side effects or problems your child had in using the suggested treatment:

   _____

   _____

6. Medication and Self Care

a) Is your student able to monitor and prevent their own exposures? ☐ YES ☐ NO

b) Does your student: **(1–4 for food allergies only)**

1. **Know about which foods to avoid?** ☐ YES ☐ NO
2. **Ask about food ingredients?** ☐ YES ☐ NO
3. **Read and understand food labels?** ☐ YES ☐ NO
4. **Firmly refuse problem food(s)?** ☐ YES ☐ NO
5. Wear medical alert jewelry? ☐ YES ☐ NO
6. Tell an adult immediately after exposure? ☐ YES ☐ NO
7. Tell peers and adults about the allergy to help prevent exposure? ☐ YES ☐ NO
8. Know how to use their emergency medication(s)? ☐ YES ☐ NO

c) Has your child ever administered their own emergency medication? ☐ YES ☐ NO

d) If your child is prescribed emergency medication, while at school, it will be kept:

1. Epinephrine Pen □ in the clinic □ in their backpack / purse (**only** for independent students)
2. Benadryl □ in the clinic

7. General Health

a) Does your child have asthma? Asthma increases the risk of severe reaction. ☐ YES ☐ NO

If yes, please provide your campus nurse with an Asthma Action Plan and discuss location of inhalers.

b) Does your child have any other health conditions? _____

8. Agreements

a) If you want the allergy noted in the cafeteria computer system, a medical doctor's note with specific allergies and precautions must be provided. ☐ Parent/Guardian Agrees

b) All medications to be taken at school must have a signed parent consent form provided to the campus nurse. ☐ Parent/Guardian Agrees

c) The nurse or campus administration will call an ambulance if epinephrine is administered or if no medication is provided and student has a severe allergy. ☐ Parent/Guardian Agrees

d) A responsibility contract must also be signed and turned in to the campus nurse with this history form. ☐ Parent/Guardian Agrees

****FOR CAMPUS NURSE DOCUMENTATION****

☐ Responsibility Contract Received ☐ Skyward Critical Alert information documented if needed

☐ Doctor's note given to dietary if applicable ☐ Medication and signed consent forms received

☐ Signs posted if inhaled allergy ☐ Asthma Action Plan reviewed

Location of inhaler and/or Epinephrine Pen: _____

Other comments / information: _____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____

Campus Nurse: _____ Date: _____

Director of Nursing: _____ Date: _____