CUSD#303
SEVERE LIFE-THREATENING ALLERGY
HEALTH HISTORY

Student Name: _____Date of Birth: _____Grade: _____

Healthcare Provider's Name: _____Phone: _____

Diagnosis (note specific allergens):_____

Does the student have asthma? ☐ Yes ☐ No (Asthma can increase the severity of a reaction)

Other Health Concerns: _____

At what age was the student diagnosed with an allergy? _____

Has the student experienced an anaphylactic reaction? ☐ Yes ☐ No

Has the student ever received epinephrine? ☐ Yes ☐ No

What symptoms led to the diagnosis? _____

What are the student's usual symptoms? _____

Approximately how many allergic reactions has the student experienced? _____

When was his/her last allergic reaction? _____

Has the student been hospitalized as a result of an allergic reaction?

☐ Yes How many times? _____ ☐ No

What treatment does the student usually require for an allergic reaction? _____

Has the student experienced an allergic reaction at school before? _____

If so, please describe the latest incident: _____

_____

Does the student have an early awareness of the onset of an allergic reaction? _____

Can the student self-administer: ☐ Inhaler ☐ EpiPen ☐ Antihistamine

Will this student self-carry rescue medication? ☐ Yes ☐ No

Is there anything else that the school should know to take the best care we can of your student?

_____

All school health information is handled in a respectful and confidential manner. May the school health office staff share this information with school staff on a need-to-know basis?

☐ Yes ☐ No

Parent/Guardian Signature: _____Date: _____