AUGUSTINIAN ACADEMY

317 West Street, Carthage, NY 13619
(315)493-1301, FAX (315)493-0632
www.caugustinian.org

Food Allergy Health History Form

Name of Student: _____ **Date of Birth:** _____ **Grade:** ____

Parent/Guardian Name: _____ **Phone:** _____

Primary Healthcare Provider: _____ **Phone:** _____

Allergist: _____ **Phone:** _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: ☐No ☐Yes (please attach documentation)
   Documentation must be provided to the school if requesting food substitutes.

2. **History and Current Status**
   Please be specific as possible, label whether they can have cooked or not, etc.

Allergy to: (circle)	List type of reaction: (i.e. itching, hives, throat swelling)
Peanuts	
Eggs	
Tree Nuts (walnuts, pecans, etc.)	
Milk	
Soy	
Fish/Shellfish	
Other:	

Additional Comments: _____

_____

_____

3. How is your child's reaction triggered? ☐ Ingested ☐ Touch ☐ Inhaled ☐ Other:_____

4. Does your child have prescribed medication for this allergy?
   ☐ No ☐ **Yes**, ***please have your Healthcare provider complete the Allergy Emergency Action Plan***

5. Have you ever had to use an EpiPen for this allergy? ☐ No ☐ **Yes**, how many times?_____

6. Does your child need to sit at a "safe" table for lunch? ☐ No ☐ Yes

7. Is your child able to monitor and prevent his/her own exposures? ☐ No ☐ Yes

8. Does your child know what foods to avoid? ☐ No ☐ Yes

9. Is your child able to tell peers and adults about their allergy and refuse a problem food? ☐ No ☐ Yes

_____

Parent's Signature **Date**

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ALLERGY EMERGENCY ACTION PLAN

Name of Student: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone: _____

Allergies: _____

Asthma: ☐Yes *(high risk for severe reaction)* ☐No

Additional health problems besides anaphylaxis: _____

Concurrent medications: _____

Symptoms of Anaphylaxis

MOUTH	itching, swelling of lips and/or tongue
THROAT*	itching, tightness/closure, hoarseness
SKIN	itching, hives, redness, swelling
GUT	vomiting, diarrhea, cramps
LUNG*	shortness of breath, cough, wheeze
HEART*	weak pulse, dizziness, passing out

Give Checked Medication	
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine
☐ Epinephrine	☐ Antihistamine

Only a few symptoms may be present. Severity of symptoms can change quickly.
**Some symptoms can be life-threatening. ACT FAST!*

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1. Inject epinephrine in thigh using (check one):
   ☐ EpiPen Jr (0.15 mg) ☐ EpiPen (0.3 mg)
   Epinephrine Auto-injector- authorized generic
   ☐ (0.15 mg) ☐ (0.3 mg)

Permission to self-carry
(check one) ☐ YES ☐ NO
By checking YES, you attest that the student has demonstrated proper knowledge of using this medication.

2. Call 911 if Epinephrine is administered!
3. Antihistamine: Benadryl or Diphenhydramine HCL, Dosage _____ every ____ hours PRN
4. Other: Albuterol HFA 2 puffs INH every ___ hours PRN coughing, wheezing, shortness of breath
5. Emergency contact: _____ home_____ work_____ cell_____

Comments: _____

_____
Doctor's Signature Date Phone Number

_____
Parent's Signature Date