Edmonds SCHOOL DISTRICT
Each student learning, every day!

Student Health Services
Allergy Information Form - Initial

Student: _____ Grade: ____ Birthdate: _____ School:_____

The following information will help the nurse in determining any special needs for your student at school. Once completed, return this form to your school nurse. If your student's allergy is not food-related, skip questions related to food.

1. What is your student allergic to? ❑ Peanuts ❑ Treenuts ❑ Wheat ❑ Eggs ❑ Fish ❑ Shellfish ❑ Milk ❑ Soy ❑ Latex ❑ Bee/Insect Stings ❑ Other: _____
2. Did your student's healthcare provider tell you this allergy could be life-threatening? ❑ YES ❑ NO
3. Has your student been prescribed an EpiPen? ❑ YES ❑ NO
4. Has your student had allergy testing? ❑ NO ❑ YES, when & where: _____
5. Does your student have asthma? ❑ NO ❑ YES, triggers:_____
   Do they have prescribed asthma medicine? ❑ NO ❑ YES, what (daily & as needed):_____
6. Does your student have environmental or seasonal allergies? ❑ NO ❑ YES, to what:_____
   Do they take allergy medication? ❑ NO ❑ YES, what (daily & as needed):_____

Reaction History

7. How old was your student when allergy was first discovered? _____
8. How many times has your student had a reaction? ❑ Never ❑ Once ❑ More than once:_____
   Date of last reaction:_____
9. How soon did reaction occur after contact with allergen? ❑ Seconds ❑ Minutes ❑ Hours ❑ Days
10. Please describe reaction (be specific, early and late signs/symptoms, time from exposure, etc.): _____
    _____
    _____
11. Did you give medication? ❑ NO ❑ YES, what? _____
    Did medication resolve the reaction? ❑ YES ❑ NO, explain: _____
12. Has an EpiPen been given before? ❑ NO ❑ YES, how many doses were given before symptoms resolved? _____
13. Has your student ever needed treatment at a clinic or hospital for an allergic reaction? ❑ NO ❑ YES, describe: _____
    _____
14. Over time are reactions: ❑ Staying the same ❑ Getting better ❑ Getting worse ❑ I don't know
15. Has your student reacted to allergen by: ❑ Eating/ingesting food ❑ Touching food ❑ Smelling food

Independence

16. Does your student:

Know what their allergy is?	❑ Yes ❑ No
Know not to share or trade food/utensils?	❑ Yes ❑ No
Tell an adult if they've had an exposure or symptoms?	❑ Yes ❑ No
Know how to use their EpiPen?	❑ Yes ❑ No
Know how to read food labels and determine if a food is allergen-free?	❑ Yes ❑ No
Independently avoid foods that cause allergic reaction? Are they able to self-monitor their allergies competently and independently?	❑ Yes ❑ No

Care Coordination

17. List primary care provider and specialists involved in your child's care:

Physician	Type of Provider	Date Last Seen	Phone

18. Does your student have health insurance? ❑ NO ❑ YES, which one? _____
19. Are you having challenges getting allergy medication or connecting with a doctor? ❑ NO ❑ YES

OVER →

School Planning

Allergy to:	Severity:	Symptoms:	Recommended Medication for Reactions:	Provide this for School?	Student to Self-Carry	Need Allergy-Free Eating Area	Need School Meal Accommodations?
	❑ Mild ❑ Moderate ❑Severe ❑ Life-Threatening	❑ Itching ❑ hives ❑ rash ❑ tingling ❑ swelling, where:_______________ ❑ cough ❑ wheeze ❑ hoarseness ❑ difficulty breathing ❑ dizziness ❑ nausea ❑ cramps ❑ vomiting ❑ diarrhea ❑ eczema ❑ other: ______________________	❑ None ❑ EpiPen ❑ Benadryl or Antihistamine ❑ Inhaler ❑ Other: ____________	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ No. Student will eat meals from home. ❑ No. Parent/student will monitor menu and choose accordingly. ❑ Yes. Student will need specialized school meals.
	❑ Mild ❑ Moderate ❑Severe ❑ Life-Threatening	❑ Itching ❑ hives ❑ rash ❑ tingling ❑ swelling, where:_______________ ❑ cough ❑ wheeze ❑ hoarseness ❑ difficulty breathing ❑ dizziness ❑ nausea ❑ cramps ❑ vomiting ❑ diarrhea ❑ eczema ❑ other: ______________________	❑ None ❑ EpiPen ❑ Benadryl or Antihistamine ❑ Inhaler ❑ Other: ____________	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ No. Student will eat meals from home. ❑ No. Parent/student will monitor menu and choose accordingly. ❑ Yes. Student will need specialized school meals.
	❑ Mild ❑ Moderate ❑Severe ❑ Life-Threatening	❑ Itching ❑ hives ❑ rash ❑ tingling ❑ swelling, where:_______________ ❑ cough ❑ wheeze ❑ hoarseness ❑ difficulty breathing ❑ dizziness ❑ nausea ❑ cramps ❑ vomiting ❑ diarrhea ❑ eczema ❑ other: ______________________	❑ None ❑ EpiPen ❑ Benadryl or Antihistamine ❑ Inhaler ❑ Other: ____________	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ No. Student will eat meals from home. ❑ No. Parent/student will monitor menu and choose accordingly. ❑ Yes. Student will need specialized school meals.

20. Is your student involved in school-sponsored activities or sports outside the school day?
    ❑ NO ❑ YES*, what? ____
    *(*It is responsibility of parent to inform adult/coach of student's condition.)*
21. ***For 5th-12th grade:*** Can your student carry and self-administer medication and independently manage their allergies? ❑ NO ❑ YES* *(*Requires authorization from nurse, parent, and health provider.)*
22. ***For elementary:*** Do we have your permission for students in the classroom to know of this allergy?
    ❑ NO ❑ YES
23. Does your student take the school bus to school? ❑ Never ❑ Sometimes ❑ Always
    For bus-riders, should your student sit up front, close to the driver? ❑ NO ❑ YES

24. List emergency contacts for your student (name, relationship, phone)

A.

B.

______________________________ ____________ ____________________

Parent/Guardian Signature & Relationship ***Date*** ***Email Address***