HOWARD COUNTY
PUBLIC SCHOOL SYSTEM

SCHOOL HEALTH SERVICES
FOOD/ALLERGEN HISTORY RECORD

DATE _____

To The Parents/Guardian of _____ Grade _____ Date of Birth _____

Our records indicate that your child has an allergy. In order for school personnel to respond to an allergic episode quickly and effectively, additional information concerning this allergy would be helpful. The information you supply will be kept confidential and shared with staff on a need-to-know basis.

Please answer the following and circle where applicable:

1. Do you consider this allergy to be life threatening to your child? YES NO

2. What is the date of your child's last allergic reaction? _____

3. Please check any type of allergy:

- ☐ Peanuts and peanut products
- ☐ Tree nuts: (fill in kind)_____
- ☐ Eggs
- ☐ Cow's milk products
- ☐ Latex
- ☐ Other _____
- ☐ Fish
- ☐ Shellfish (shrimp, crabs, clams, etc.)
- ☐ Corn
- ☐ Wheat
- ☐ Soybeans and soy formula

4. Does your child know to avoid these foods or the allergen and their by-products? YES NO

5. Please check only those symptoms which you have observed when your child has had an allergic reaction. ***(Please check all that apply)***

- ☐ Itching or swelling of lips, tongue, or mouth
- ☐ Nasal congestion
- ☐ Runny nose, sneezing, or sniffling
- ☐ Itching or sense of tightness in the throat
- ☐ Sore throat or throat clearing, "hacking" cough
- ☐ Hoarseness
- ☐ Nausea or vomiting
- ☐ Abdominal cramps or diarrhea
- ☐ Hives, itchy red skin/rash
- ☐ Swelling about the face or extremities
- ☐ Difficulty breathing, shortness of breath or wheezing
- ☐ Difficulty swallowing or choking
- ☐ Repetitive coughing
- ☐ Dizziness or fainting
- ☐ Shock (fall in blood pressure and increased thready pulse rate).
- ☐ Unconsciousness
- ☐ Other _____

6. How long after exposure to the allergen did your child develop symptoms? ***(Please check all that apply)***

- ☐ Immediately
- ☐ Within 15-20 minutes
- ☐ Within an hour
- ☐ Longer than one hour (specify time) _____

7. Has your child ever been hospitalized (emergency room) for an allergic reaction? YES NO

   a. Has your child ever received an Epinephrine outside of the hospital? YES NO
   b. What is the date of the last Epinephrine administration? _____

8. Does your child take medication for allergy symptoms? YES NO

   a. Does your child take diphenhydramine (Benadryl) or other antihistamine? YES NO
   b. Does your child have Epinephrine/adrenalin ordered? YES NO
   c. Can your child self-administer Epinephrine? YES NO

The Howard County School System does not encourage the routine administration of medication in the school setting. However, if medication is necessary at school, a written health care provider's order and signed parent permission are required to be on file in the health room. Please consult with the health assistant or school nurse for forms and further information.

9. Will your child be eating school-prepared lunches? YES NO

10. Do you request for your child to sit at the peanut free table at lunch? YES NO

11. Will your child be eating lunches and snacks prepared only at home? YES NO

12. Does your child wear a medical alert bracelet that lists the specific allergies? YES NO

13. Do you give permission for school personnel to contact the student's health care providers? YES NO

14. Pediatrician's Name _____ Phone _____

    Allergist's Name _____ Phone _____

PARENT SIGNATURE _____ **Date** _____

Please share any **ADDITIONAL INFORMATION** with the School Nurse and Health Assistant below:

_____

_____

_____

Would you like to be contacted by the School Nurse? YES NO

Contact Name _____

Contact Number _____ Best Time to Contact _____

HEALTH ROOM USE ONLY

Form **Received** –Date: _____ | Form **Reviewed** –Date: _____

Signed: _____ | Signed: _____