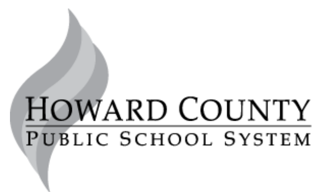

SCHOOL HEALTH SERVICES
POLLEN/SEASONAL/ANIMAL ALLERGY HISTORY RECORD

DATE ___________________________________

To The Parents/Guardian of ______________________________Grade ________ Date of Birth _______________

Our records indicate that your child has pollen, seasonal and/or animal allergies. In order for school personnel to respond to this health concern quickly and effectively, additional information concerning these allergies 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. When was the diagnosis made? ____

2. Please list the allergens that trigger a reaction in your child (for example: type of flower, plant or tree pollen; type of animal; dust, molds, etc.):
   ____
   ____
   ____

3. Please indicate the symptoms you have observed when your child has had an allergic reaction to any of the above listed allergens: ***(Please check all that apply)***
   - ☐ Nasal congestion
   - ☐ Runny nose, sneezing, or sniffling
   - ☐ Itching or sense of tightness in throat
   - ☐ Hoarseness
   - ☐ Hives, itchy, red skin or rash
   - ☐ Red, itchy, or watery eyes
   - ☐ Sore throat or throat clearing, “hacking cough
   - ☐ Swelling about the face or extremities
   - ☐ Difficulty breathing, shortness of breath or wheezing
   - ☐ Repetitive coughing
   - ☐ Dizziness or fainting
   - ☐ Nausea or vomiting
   - ☐ Other ____

4. How do you treat this at home? (Please include names of medications used) _____________________________
   ____
   ____
   ____

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 providers'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.

5. Are there any restrictions or limitations? YES NO

   If yes, describe:____

   If your child requires activity restrictions, HCPSS form 39513040- Physical Education / Activity Assessment Form, must be completed annually, by the health care provider, in order to be excused from certain curriculum.

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

   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: ____________________

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