Severe Allergies & Anaphylaxis
Health Intake Form
REV. 8-31-2020

Student's Name:_____ **DOB:**___/___/___ **Grade:**_____ **Today's Date:**___/___/_____

Name of physician treating student's allergies:_____ **Phone Number:** _____

Medical alert jewelry worn? ☐ Yes ☐ No

Mode of transportation to and from school?_____

Does student participate in before or after school activities? ☐ Yes ☐ No **Activity:**

_____

Does student have a diagnosis of severe allergy from a healthcare provider? ☐ Yes ☐ No

Student is allergic to (check all that apply):

☐ Peanuts ☐ Tree Nuts ☐ Eggs ☐ Milk ☐ Fish ☐ Shellfish ☐ Soy ☐ Wheat ☐ Bee Stings ☐ Latex

☐ Other: _____

_____

Describe student's allergic reaction:

_____

Age or date: _____

Symptoms:_____

Allergen (if known): _____

How quickly symptoms appeared after exposure:_____

Severity (including need for hospitalization): _____

Please check *all* symptoms that student has experienced in the past:

Skin: ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling (face, arms, hands, legs)

Mouth: ☐ Itching ☐ Swelling (lips, tongue, mouth)

Abdominal: ☐ Nausea ☐ Cramps ☐ Vomiting ☐

Diarrhea *Throat:* ☐ Itching ☐ Tightness ☐

Hoarseness ☐Cough

Lungs: ☐ Shortness of breath ☐ Repetitive cough ☐ Wheezing

Heart: ☐ Weak pulse ☐ Loss of consciousness

Has an epinephrine injection (such as EpiPen) **been given for a past allergic reaction?** ☐ Yes ☐ No

If yes, how many times has epinephrine been administered? _____

Student self-care (Please indicate student's skill level for the following):

Meal plan:

Knows what foods to avoid	☐ Yes	☐ No
Asks about food ingredients	☐ Yes	☐ No
Reads and understands food labels	☐ Yes	☐ No
Tells an adult immediately after an exposure	☐ Yes	☐ No
Tells peers and adults about the allergy	☐ Yes	☐ No
Firmly refuses a problem food	☐ Yes	☐ No
Knows how to use emergency medication	☐ Yes	☐ No
Has administered emergency medication to self in the past	☐ Yes	☐ No

Will student participate in breakfast at school?_____

Will student bring lunch, eat school lunch, or both?_____

Does student regularly eat snacks at school?_____

Classroom snacks/birthday treats from other students: We recommend that parents/guardians provide a supply of individualized snacks for early childhood and younger elementary-age students with known food allergies. Please indicate your preference by ***selecting <u>one</u>*** of the following:

_____I will provide ***all*** of my student's food. He/she **is not to eat** other snacks/treats at school unless I am present or have provided ***prior written approval*** specific to the item.

_____My student knows about foods to avoid and **may eat** snacks/treats provided by others.

Parent/Guardian Signature:_____ **Date:** _____