Catholic Schools of Fairbanks

FOOD ALLERGY HEALTH HISTORY FORM

Student Name:_____ Date of Birth:_____

Parent/Guardian: _____ Today's Date: _____

Home #: _____ Cell #: _____ Work #: _____

1. Does your child have a diagnosis of an allergy from a health care provider? **Y** **N**

HISTORY AND CURRENT STATUS

What is your child allergic to:

- ○ Peanuts
- ○ Eggs
- ○ Milk
- ○ Latex
- ○ Soy
- ○ Fish/Shellfish
- ○ Tree Nuts
- ○ Gluten
- ○ Other: _____

_____

Age of the student when allergy was first discovered: _____

How many times has the student had the reaction: _____

When was their last reaction? _____

Are the food allergy reactions: Same Worse Better

2. Triggers and Symptoms:

a.) What are the signs and symptoms of your child's reaction? (be specific):_____

_____

_____

b.) How quickly do the signs and symptoms occur? _____

3. Treatment

a.) Has your child ever needed treatment at a clinic or hospital for an allergic reaction: **Y** **N**

Explain: _____

b.) What treatment or medication has your health care provider recommended for use in an allergic reaction:

_____

c.) Have you used the treatment? Explain:_____

Parent/Guardian Signature: _____ Date:_____