# ALLERGIC REACTION - STUDENT HEALTH HISTORY

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|---|---|---|---|---|---|
| Student Name | | Grade | | Date of Birth | |
| Healthcare Provider Name | | Healthcare Provider Number | | | |
| **ALLERGENS** | | | | | |

Students with life threatening allergies need to submit this completed form, a current allergy action plan completed by their child's physician, and the prescribed medication to the school nurse. All forms are available on the district website at https://www.frsd.k12.nj.us/Page/108

**1. INITIAL ALLERGIC REACTION** - *IF YOUR CHILD'S ALLERGY WAS DIAGNOSED BY BLOODWORK / SKIN TEST AND HE/SHE HAS NOT HAD A REACTION, GO TO QUESTION #2*

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|---|---|
| a. Date of first reaction | |
| b. Reaction occurred from (check all that apply) ☐ ingestion ☐ contact ☐ sting | |
| c. **For each allergen** - list all symptoms/problems your child had, such as full body hives, swelling of face, difficulty breathing, diarrhea, vomiting, etc. | |

d. Did your child go to the Emergency Room or doctor's office for this reaction?

- ❑ No
- ❑ Yes Please circle one: ER Doctor
- ➢ What treatment/medicine was given?
- ➢ Was your child hospitalized: ☐ No ☐ Yes For how long: _____
- ➢ Was any testing done: ☐ bloodwork ☐ skin testing ☐ food challenge
  Test results:
- ➢ Did the health care provider prescribe medication to be given for future exposure to allergen?
  - ❑ No
  - ❑ Yes Medication: _____

e. Has your child had additional reactions to the allergen listed above? ☐ No ☐ Yes

| Date | Reaction | Treatment |
|---|---|---|
| | | |
| | | |

**GO TO QUESTION 3**

**2.** a. If your child **did not** have any reactions before being diagnosed with an allergy, was your child's allergy diagnosed by (check all that apply): ☐ Bloodwork ☐ Skin testing

| | |
|---|---|
| Date of Initial Testing: | |
| Test Results: | |

b. Did the health care provider prescribe medication to be given for future exposure to allergen?

☐ No ☐ Yes Medication: _____

**3.** Has your child had any additional testing done? ☐ No ☐ Yes

| TEST DATE | TEST RESULTS |
|---|---|
| | |
| | |

**4.** Does your child have any early warning signs of allergic reaction? ☐ No ☐ Yes

Early Signs:

**5.** INSECT/STING ALLERGY

- ➢ Has desensitization been recommended? ☐ Yes ☐ No
- ➢ Is your child currently undergoing desensitization? ☐ Yes ☐ No
- ➢ Has desensitization been completed? ☐ Yes ☐ No

**6.** Please list all medications prescribed for your child's allergies

**7.** Does your child have asthma? ☐ Yes ☐ No

*If yes, students with asthma must complete a completed Asthma - Student Health History form, have your doctor complete an Asthma Treatment Plan, and bring completed forms and prescribed medication to the school nurse. All forms are available on the district website at https://www.frsd.k12.nj.us/Page/108*

*All medications must be brought in by a parent and kept in the health office (as per district policy) unless approval has been given by the health office and the student's physician for a student to carry medication with him/her. If your child has permission to carry an epinephrine auto-injector with him/her, please send an extra to be kept in the health office in the event your child forgets to bring it to school.*
*All medication forms (including allergy and asthma forms) are required to be updated and resubmitted each school year at the beginning of the year. Failure to do so may compromise our ability to safely care for your child. If you have any questions, please contact your child's school nurse.*

| PARENT/GUARDIAN SIGNATURE | DATE |
|---|---|
| | |

It is strongly recommended all children wear a medic alert bracelet at all times. Please remember that there are staff members and substitute nurses who may not be familiar with your child on first glance. Also, they ride the bus, and in an emergency, the police /EMT will be looking for a medic alert bracelet.