STUDENT SEVERE ALLERGIC REACTION HISTORY

STUDENT Student Name and DOB	
ALLERGENS Tell me what your student has had a severe allergic reaction to.	
TRIGGERS Tell me about specific allergic triggers for your child? (please specify)	☐ Exercise ☐ Heat ☐ Cold
TYPE OFSYMPTOMS Tell me about what type of symptoms your child experienced.	☐ Facial swelling ☐ Throat swelling ☐ Hives or rash ☐ Difficulty breathing or swallowing ☐ Hoarseness ☐ Burning sensation ☐ Changes in skin color ☐ Sneezing/wheezing/coughing ☐ Abdominal pain ☐ Nausea/ vomiting/ diarrhea ☐ Other (describe below:)
ONSET When was your child's first reaction?	
FREQUENCY How often does your child experience severe allergic reactions?	
SENSITIVITY How does your child's reaction occur?	☐ Direct Contact ☐ Inhalation ☐ Ingestion only ☐ Sting
CO-OCCURRING CONDITIONS Does your child have asthma or another immune mediated condition?	
MEDICATION What has your child been prescribed for allergic reactions?	
HISTORY Has your child required emergency care or hospitalization secondary to a severe allergic reaction?	
PROVIDER Who is your child's allergist or immunologist?	
ACCOMODATIONS Does your child require any accommodations related to allergies?	
RESTRICTIONS **Does your child have any restrictions related to allergies?**	
FORM COMPLETION Who completed this form? Date?	