FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
HEALTH HISTORY AND CONSENT-SEVERE ALLERGY

Student: _____ **DOB**_____ **Teacher:** _____ **Grade:** _____
School: _____**Parent/Guardian & Phone(s):** _____
Physician & Phone: _____ **School Year:** _____
KNOWN ALLERGIES: _____

Dear Parent/Guardian:
School records or medical information indicates your child has allergies or a severe allergy. In order to attend to your child's health and safety, the school requires a health history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record. Our primary concern is that your child's healthcare needs are met while in school.

_____ _____ _____
School Nurse Phone number Date

1. **What is your child allergic to?** (Circle all that apply)
Insect bites- bees, wasps, hornets, yellow jackets, fire ants, mosquitoes, spiders, other: _____
Foods- peanuts, all nuts, milk, all dairy, eggs, wheat, soy, chocolate, mango, shellfish, fish, other: _____
Latex rubber **and/or** any **Medications** (list) _____
Other Allergen- pollen, dust, smoke, animal dander, chemical fumes, other: _____
2. How many times has your child had an allergic reaction? Once 2-3 times other _____
3. Has your child ever been hospitalized for a severe reaction? No Yes If yes, when? _____
4. Describe your child's usual symptoms: _____
5. How have you treated allergic reactions? _____
6. List any medications your child takes daily for allergies:

Name of Medication	Dosage	Time

Does your child have any "as needed" medications or **emergency medications**? _____
7. Does your child take any **other** medications?

Name of Medication	Dosage	Time

8. List any side effects your child experiences from his/her medication? _____
9. Self-Care: Please circle responses

a.	Is your child able to monitor and prevent their own exposures?	No	Yes
b.	Does your child:		
	1. Know what foods to avoid	No	Yes
	2. Ask about food ingredients	No	Yes
	3. Read and understands food labels	No	Yes
	4. Tell an adult immediately after an exposure	No	Yes
	5. Wear a medical alert bracelet, necklace, watchband	No	Yes
	6. Firmly refuses a problem food	No	Yes
c.	Does your child know how to use emergency medication?	No	Yes
d.	Has your child ever administered their own emergency medication?	No	Yes

CONSENT

Please circle your response and sign:**(I do /I do not) give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.**

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____