Glen Ellyn School District 41
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793 North Main Street, Glen Ellyn, IL 60137

ALLERGY HISTORY FORM **SCHOOL YEAR _____**

Student Name _____School _____Grade _____

According to your child's health records he/she has allergies to the following foods: 7:285 E2

_____

Please provide us with additional information regarding your child's health needs by answering the questions below; sign and return the form to your school nurse.

1. At what age did your child experience their first allergic reaction? _____
2. Please indicate by which method of exposure causes an allergic reaction:
   _____eating _____inhaling
   _____touching _____other _____
3. Please describe the type of allergic reaction he/she has had in the past. Check all that apply:
   _____itching, tingling, or swelling of the lips, tongue, mouth
   _____hives, itchy rash, swelling of the face or extremities
   _____nausea, abdominal cramps, vomiting, diarrhea
   _____tightening of the throat, hoarseness, hacking cough
   _____shortness of breath, repetitive coughing, wheezing
   _____fainting, pale, blueness
   other _____
4. Has your child seen a doctor for this food allergy? _____
5. Has your child been treated in an emergency room because of an allergic reaction to food? If so, what medication was administered?
   _____
   _____
6. When was the last time your child had an allergic reaction to food?_____
7. How do you treat allergic reaction to food at home?_____
   _____
8. Does your child have an emergency auto injector at home? _____
   If yes, does your child know how to use the emergency auto injector? _____Yes _____No

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE

Reviewed: January 18, 2011, January 11, 2016
Adopted: January 18, 2011
Revisions: January 25, 2016

Parent/Guardian Signature: _____Date: _____