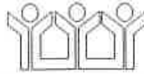

BEDFORD CENTRAL SCHOOL DISTRICT
School Health Services
THE FOX LANE CAMPUS, P O BOX 180
MOUNT KISCO, NEW YORK 10549
914-241-6000

Dr. Robert Glass
Superintendent of Schools

Dr. Louis Corsaro
Medical Director

Food Allergy History

Student Name: .... Grade/Teacher: ....

Date of Birth: .... Weight: ....

Parent/Guardian: ....

Contact Phone Number: ....

Primary Healthcare Provider/Allergist: ....

1. What is your child allergic to? ....

   ....

2. Is the allergy tactile, ingestion or airborne? (**Circle all that apply**).

3. **Please circle** the symptoms that your child has experienced in the past:

   - **Skin**: localized hives, systemic (all body) hives, itching, rash, flushing, swelling of eyes/face/hands/arms/legs
   - **Mouth**: itching, obstructive swelling of lips/tongue/mouth
   - **Abdominal**: nausea, cramps, vomiting, diarrhea
   - **Throat**: itching, tightness, hoarseness, cough, trouble swallowing
   - **Lungs**: shortness of breath, repetitive cough, wheezing
   - **Heart**: chest pain or tightness, weak pulse, dizzy, confusion, paleness, loss of consciousness, cyanosis (blueness)
   - **Generalized feeling of doom/or that something bad is going to happen**

4. What age was your child when the allergy was discovered? ....

   How was it discovered? ....

5. How many times has your child had a mild reaction requiring the use of an antihistamine (ie:Benadryl)? ....

   What symptoms did your child have at this time? ....

6. Has your child ever had an anaphylactic (severe reaction)? Did it require the use of an epinephrine pen? .... If so, how many times? ....