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** ☐ **airborne?** (Check all that apply)

3. Please check 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?

7. Has your child ever been hospitalized or sent to the emergency room related to their food allergy? If yes, please explain:

8. What are the *early* symptoms of your child having an allergic reaction?

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9. How does your child communicate his/her symptoms?
10. Is your child allowed to touch, play or eat with foods used in classroom activities that may have been processed in the same facility as the allergen that your child has? Is your child able to eat foods that have a food allergy warning on the package?
11. Does your child need to sit at a nut free table at lunchtime? ☐ Yes ☐ No
12. Is your child asthmatic? If so, have they ever been hospitalized due to an asthmatic episode? Has a rescue inhaler been prescribed and do they use an aero chamber?

Checklist

- The Food Allergy Action Plan has been provided and reviewed with the School Nurse who will review it with the primary teacher(s).
- Two epinephrine pens along with a physician's prescription have been provided to the School Nurse. If my child is asthmatic, a rescue inhaler has been provided with an aero-chamber to the School Nurse.
- It is my responsibility to pick up my child's epinephrine pens at the end of the school year from the School Nurse.
- **Please provide your child's teacher with a safe food option (to be kept in the classroom) for all classroom birthday and holiday celebrations or special events.**

Parent Name: _____ Date: _____

Signature of Parent: _____