Byram Hills Central School District
Health Services Department

Health History for Students with Allergies

Student Name: _____ Date of Birth: _____
School: _____ Grade: _____

Primary Health Concern: _____

Secondary Health Concern: _____

Healthcare Provider's Name: _____ Phone: _____

Diagnosis (note specific allergens): _____

At what age was the student diagnosed with an allergy? _____

What symptoms led to the diagnosis? _____

What are the student's usual symptoms? _____
_____

Approximately how many allergic reactions has the student experienced? _____

When was his/her last reaction? _____

Has the student been hospitalized as a result of an allergic reaction?
Yes – How many times? _____ No _____

Does the student have early awareness of the onset of an allergic reaction? _____

What treatment does the student usually require for an allergic reaction? _____
_____

Has the student experienced an allergic reaction at school before? _____

Does the student have Asthma? No ___ Yes ___ How have previous allergic reactions affected his/her Asthma? _____

Is the student self-directed? _____

Has the student had skin testing for allergies? _____

Has the student had blood tests for allergies? _____

What strategies have worked for preventing exposure for your child? _____
_____

Is there anything else we should know? _____

All school health information is handled in a respectful and confidential manner. May the school health office share this information with school staff on a "need to know" basis? Yes No
Additional comments: _____

Parent / Guardian Signature: _____ Date: _____

Revised 1/09