ROCKLIN ACADEMY
FAMILY OF SCHOOLS

ALLERGY HISTORY INFORMATION

STUDENT_____**BIRTH DATE**_____

SCHOOL_____**GRADE**_____**TEACHER**_____

Dear Parent:
According to your child's health records, you have indicated that he/she has an allergy.
Please complete the appropriate section below and return it to school so that we have additional information about the condition. if your child has more than one allergy and reacts differently to each please be specific regarding each reaction.
If you child no longer has this condition, please let us know. Forms for medications at school are available on the school website or in the health office.

Thank you,

Stephanie Keenan RN BSN
Credentialed School Nurse
Rocklin Academy Family of Schools

History of ALLERGIC REACTIONS (PLEASE FILL OUT IF APPLICABLE)

What was the allergen:_____Total # of reactions:_____

Treatment provided:_____

Date of last reaction:_____

I would classify my child's allergy as:
❑ MILD ❑ MODERATE ❑ SEVERE ❑ MY CHILD NO LONGER HAS THIS CONDITION

Other information (check if applicable): ❑ Asthma ❑ Inhaler at school ❑ Medical ID worn

How soon after contact does your child react? _____ minutes_____ hours_____ days

What are the early warning signs that indicate your child is starting to have an allergic reaction?
_____

Does he or she recognize these warning signs? • **Yes** • **No**

Please mark what your child does to prevent or avoid an allergic reaction:

_____ ⍞Knows what to avoid
_____ ⍞Tells others about his or her allergies
_____ ⍞Tells an adult **immediately** if exposed to an allergen
_____ ⍞Asks about ingredients in foods, if unsure about contents
_____ ⍞Firmly refuses food that might be a problem food

Please indicate symptoms that your child has experienced with previous reactions (mark all that apply):

☐All over tingling or itching	☐Vomiting, stomach cramping or diarrhea
☐All over rash or hives	☐Wheezing or difficulty breathing
☐Coughing or sneezing	☐Blue or gray discoloration of lips or fingernails
☐Sudden mood change	☐Dizziness or fainting
☐Red face	☐Seizures
☐Tightness of throat and/or chest	☐Loss of consciousness
☐Swelling of eyes, lips, tongue, throat or neck	☐Overall feeling of unwell
	☐Other_____

Please list all medications prescribed/recommended by a health care provider to treat your child's allergic reactions.

Medications:

_____

_____

Does this student need to sit at a peanut/nut free table: **• Yes • No**

May we include your child's name and image on a confidential site wide health concerns list for supervising staff **• Yes • No**

Teacher will notify parent in advance of parties/special food in the classroom. Parent will determine whether their student can eat food being provided and/or provide a safe alternative snack.

PARENT SIGNATURE_____DATE_____

PARENT PRINTED NAME_____

BEST DAY CONTACT/EMERGENCY NUMBER_____