GILL ELEMENTARY SCHOOL

48 Boyle Rd.
Gill, MA 01354
Phone: (413) 863-3255

Health History – Caring for Students with Allergies

Student Name: ____________________________Date of Birth: ______________Grade: _____

Primary Health Concern: ____

Secondary Health Concern(s): ____

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 allergic reaction? ____

Has the student been hospitalized as a result of an allergic reaction?

Yes How many times? ____________ No

Does the student have an 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? ________________________

If so, please describe the latest incident: ____

____

Does the student have asthma?: Yes No (Asthma can increase the severity of a reaction) How have previous allergic reactions affected his/her asthma? ________________________________

____

Is the student self-directed? Yes No

Is there anything else that the school should know to take the best care we can of your student?

____

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

Parent/Guardian Signature ____Date _________