



# Student Severe Allergy Health History

AA-1

Parent/Guardian \_\_\_\_\_ School/Grade/Teacher \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Primary Healthcare Provider \_\_\_\_\_ Phone \_\_\_\_\_  
 Allergist \_\_\_\_\_ Phone \_\_\_\_\_

1. Does your child have a diagnosis of an allergy from a healthcare provider?     No     Yes

2. History and Current Status

3. Trigger and Symptoms

a. \_\_\_\_\_ be specific, include things the student might say

b. How does your child communicate his/her symptoms?

c.

5. Self Care

6. Family/Home

7. General