ASTHMA/ALLERGY/ANAPHYLAXIS HISTORY

Date:_____

Name:_____Birthdate:_____

Parent/Guardian Name:_____Home Phone:_____

Address:_____Work Phone:_____

Emergency Contact #1:_____ Phone:_____

Emergency Contact #2:_____ Phone:_____

Physician:_____ Phone:_____

History of Asthma: Yes_____ No_____If Yes, describe triggers:_____
_____
_____

Medications or Treatments for Asthma Attack:_____
_____
_____

History of Food Allergies: Yes_____ No_____If Yes, List Foods:_____
_____

Reaction Symptoms:_____

Treatment:_____

History of Insect Allergies: Yes_____ No_____If Yes, List type of insect:_____
_____

Reaction Symptoms:_____

Treatment:_____

History of Other Allergies (medications, hay fever, latex, pollen, etc.) Yes_____No_____

Reaction Symptoms:_____

Treatment:_____

Has this child ever had an Anaphylactic Reaction? Yes_____ No____

If Yes, what triggered this reaction? _____
_____