The Country School
341 Opening Hill Road
Madison, CT 06443
(230) 421.3113 EXT. 111

FOOD / NUT ALLERGY HISTORY

Student: _____ **DOB:** _____ Grade: _____

Dr: _____**Phone:** _____

LIFE-THREATENING ALLERGIES:

ALLERGIES being treated **by DR.**_____

FIRST DIAGNOSED: (Initial exposure, Reason for EPIPEN prescription}:

MEDICAL HISTORY::(Including each use of EPIPEN)

HOSPITALIZATIONS: {including Emergency Room Visits}

SIGNS / SYMPTOMS that child exhibited during allergy attack:

- **Itching / Swelling of lips, tongue, mouth or throat**
- **Shortness of breath, wheezing**
- **Hacking cough, hoarseness**
- **Hives, rash, swelling of face or extremities**
- **Metallic taste in mouth**
- **Nausea, vomiting**
- **Abdominal cramps, diarrhea**
- **Thready pulse, "passing out"**

Date	Age	Describe incident leading to diagnosis of Life-threatening allergy and every following anaphylactic incident.

Parent Signature _____**Date:** ____/_____/20_____