Food Allergy Assessment Form

Student Name: ______________________________________ Date of Birth: ______________ Date: _________________

Health Care Provider (name) treating food allergy: _________________________ Phone: _____________

Do **you think** your child's food allergy may be **life-threatening**? q No q Yes
(If YES, please contact the school nurse as soon as possible).

Did your student's **health care provider tell you** the food allergy may be **life-threatening**? q No q Yes

(If Yes, please contact the school nurse as soon as possible.)

History and Current Status

Check the foods that have caused an allergic reaction:

q Peanuts q Fish/shellfish q Eggs
q Peanut or nut butter q Soy products q Milk
q Peanut or nut oils q Tree nuts (walnuts, almonds, pecans, etc.)
Please list any others: ____

How many times has your student had a reaction? q Never q Once q More than once, explain: ______________________

When was the last reaction? _____________________

Are the food allergy reactions: q staying the same q getting worse q getting better

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? *(Check all that apply)*

q Eating foods q Touching foods q Smelling/Inhaling foods q Other, please explain:_______________________________

____

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)*___________

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How quickly do the signs and symptoms appear after exposure to the food(s)?

_____ Seconds _____Minutes _____ Hours _____Days

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?
q No q Yes, explain: ____
Does your student understand how to avoid foods that cause allergic reactions? q Yes q No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

____

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Have you used the treatment? q No q Yes

Does your student know how to use the treatment? q No q Yes

Please describe any side effects or problems your child had in using the suggested treatment:_______________________

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If you intend for your child to eat school provided meals, have you filled out a diet order form for school?

RN Review: __________ SIS:__________ ☐Notifications:
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q Yes. q No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is to be available at school, have you filled out a medication form for school?

q Yes. q No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies to school?

q Yes. q No, I need to get the medication/treatment and bring it to school.

What do you want us to do at school to help your student avoid problem foods?

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I give consent to share, with the classroom, that my child has a life-threatening food allergy. q Yes q No

Parent/Guardian Signature: ____ Date: _______________

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