Food Allergy Assessment Form

Student Name___________________________________ Date of Birth: ___________Date:____________

Parent/Guardian: ____________________________Phone:_______________ Cell/work:________________

Health Care Provider (name) treating food allergy: ____________________________Phone:_____________

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

Did your student's **health care provider tell you** the food allergy may be **life-threatening**? ______ No ______ Yes
(If **YES**, please see the school nurse as soon as possible.)

History and Current Status

Check the foods that have caused an allergic reaction:

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

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

When was the last reaction? _____________________

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

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? **(Check all that apply)**
______ Eating foods ______ Touching foods ______ Smelling foods ______ Other, please
explain:____

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

____

____

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?
______ No ______ Yes,
explain:____
Does your student understand how to avoid foods that cause allergic reactions? ______ Yes ______ No
What treatment or medication has your health care provider recommended for use in an allergic reaction?
____

____

Have you used the treatment? ____No _____ Yes

Does your student know how to use the treatment? _____ No _____ Yes
Please describe any side effects or problems your child had in using the suggested treatment:_______________________

____

____

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

_____ Yes

_____ 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?

_____Yes

_____ 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?

_____ Yes

_____ 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? ____________________________

____

I give consent to share, with the classroom, that my child has a life-threatening food allergy.

_____ Yes

_____ No

Parent Signature: ____ Date: _________________________

Reviewed by R.N.: ____ Date: __________________________