

Food Allergy Assessment Form

Student Name: _____ Date of Birth: _____ Date: _____

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Grade _____

Health Care Provider (name) treating food allergy: _____ Phone: _____

Is your child's food allergy *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:

| | | |
|---|---|-------------------------------|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Fish/shellfish | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Peanut or nut butter | <input type="checkbox"/> Soy products | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Peanut or nut oils | <input type="checkbox"/> 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 and please describe symptoms?

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 Medical Statement for Special Meals form for school (located on the District website)?

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, has the physician filled out a Severe Allergy Medical Management form for school (located on the District website)?

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 would you like us to do at school to help your student avoid problem foods?

Is it medically necessary for your child to sit at a separate table in the lunchroom?

Yes

No

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

Yes

No

Parent/Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____

