Food Allergy Assessment Form

Student Name: _______________________________ Date of Birth: ________________ Date: ____________________

Parent/Guardian: _____________________________ Phone: ______________________ Cell/Work: ________________

Heath Care Provider (name) treating food allergy: ________________________________ Phone: ___________________

Dou you think your child's food allergy may be life-threatening? ☐ No ☐ Yes (If yes, please contact the school nurse as soon as possible)

History and Current Status

Check the food that have caused an allergic reaction:

☐ Peanuts ☐ Fish/Shellfish ☐ Eggs ☐ Peanut or nut butter ☐ Soy product

☐ Milk ☐ Peanut or nut oils ☐Tree Nuts (walnuts, almonds, pecans, etc.)

Please list any other allergies: ____

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 food ☐ Touching foods ☐ Smelling/Inhaling foods ☐ other, please explain:

____

What are the signs and symptoms appear after exposure to the food?

____ 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 suggested treatment:

____

____

If you intend for your child to eat school provided meals, have you filled out a diet form for school? ☐ Yes ☐ No, I need to get a form, have it completed by your 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 a form, have it completed by your 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/Guardian Signature: ____ Date: ________________

Reviewed by RN: ____ Date: ________________