Food Allergy Assessment Form

201Ì -201J

		Today's date	______/______/______ DD MM YYYY
Student's name		Grade	
Parent or guardian		Phone	(_____)_____–_______
Healthcare provider who treats the allergy		Phone	(_____)_____–_______

Do you think your child's food allergy may be life-threatening?

❒ Yes. See the school nurse as soon as possible.
❒ No

Did your student's health care provider tell you the food allergy may be life-threatening?

❒ Yes. See the school nurse as soon as possible.
❒ No

Tell us about your child's history and current status

Which foods have caused an allergic reaction?
Check all that apply.

❒ Peanuts
❒ Fish or shellfish
❒ Eggs
❒ Peanut butter or nut butter
❒ Peanut oil or nut oil
❒ Soy products
❒ Milk
❒ Tree nuts (walnuts, almonds, pecans, etc.)
❒ Others: ______________________________

How many times has your child had a reaction?
Check all that apply.

❒ Never
❒ Once
❒ More than once. Explain: ____________________
When was the last reaction? __________________

Are the reactions …

❒ Yes

❒ No

Does your child know how to use the treatment?

❒ Yes

❒ No

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 filled out by our healthcare 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 filled out by our healthcare provider, and return it to school.

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

❒ Yes

❒ No. I need to get the medication or treatment and bring it to school.

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

____

____

____

I agree that you can share information

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

❒ Yes

❒ No

______________________________ ___________

Parent or guardian signature date

______________________________ ___________

Reviewed by R.N. date

❒ Staying the same
❒ Getting worse
❒ Getting better

Tell us about any triggers and symptoms

What has to happen for your child to react to the problem foods? *Check all that apply.*

❒ Eating foods
❒ Touching foods
❒ Smelling foods
❒ Other. Explain: ______________________________

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

____

____

____

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

❒ Seconds
❒ Minutes
❒ Hours
❒ Days

Tell us about treatment

Has your child ever needed treatment at a clinic or the hospital for an allergic reaction?

❒ Yes. Explain: ______________________________
❒ No

Does your child 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?