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 contact 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 contact 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/Inhaling 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

Adapted from OSPI Anaphylaxis Guidelines

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/Guardian Signature: _____ Date: _____

Reviewed by RN: _____ Date: _____

Adapted from OSPI Anaphylaxis Guidelines