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
- Peanut or nut butter
- Peanut or nut oils
- Fish/shellfish
- Soy products
- Tree nuts (walnuts, almonds, pecans, etc.)
- Eggs
- Milk

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