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 see the school nurse as soon as possible).

Did your student's health care provider tell you the food allergy may be life-threatening? ☐ No ☐ Ye
(If YES, please see 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 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 with permission from ESD 171 SNC