Food Allergy Assessment Form

Student Name: ______________________________________________________  Date of birth: _______________________

Parent/Guardian: ___________________________  Phone #: __________________________

Health Care Provider Name: _______________________________  Phone: __________________________

Do you think your child’s food allergy may be life threatening?  □ No  □ Yes  
(If yes, see School Nurse as soon as possible)

Did your child’s health care provider tell you the food allergy may be life threatening?  □ No  □ Yes  
(If yes, see School Nurse as soon as possible)

History and Current Status  Check the foods that have caused an allergic reaction:

☐ Peanuts  ☐ Fish/Shellfish  ☐ Tree nuts (walnuts, pecans, almonds, etc.)  
☐ Milk  ☐ Soy products  ☐ Others: _________________________________________________________________

How many times has your child 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 child to have a reaction to the problem food?

☐ Eating foods  ☐ Touching foods  ☐ Smelling foods  ☐ Other, please explain: ______________________________
__________________________________________________________________________________________

What are the signs and symptoms of your child’s allergic reaction?  (Please be specific, including things your child 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?  □ No  □ Yes
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 child 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 had filled out a Dietary Prescription form?  □  Yes  □  No, I need to obtain the form, have it completed by our healthcare provider, and return it to school.

If medication is needed at school, have you filled out a Medical Authorization form with your healthcare provider?  □  Yes  □  No, I need to obtain the form, fill it out with my healthcare 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 supplies and bring to the school.

□  No, but I have a plan with the nurse to bring medication supplies prior to the first day of school.

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

I give consent to share with the classroom that my child has a life-threatening food allergy.
□  No  □  Yes

Parent/Guardian Signature:________________________________________    Date:_________________

Reviewed by RN:________________________________________________    Date:_________________