- ☐ Student Office File
- ☐ Student Medical File
- ☐ Food Services File

Food Allergy Assessment Form (2020-2021)

CONFIDENTIAL

______________________________ ______________ ____

Student Last Name, First Name **Birth Date** **Grade**

❑ Yes ❑ No Do you think your student's food allergy may be life-threatening?
(If yes, please contact the main office as soon as possible).

❑ Yes ❑ No Did your student's health care provider inform you the food allergy may be life-threatening?
(If yes, please contact the main office as soon as possible).

History and Current Status

Check the foods that have caused an allergic reaction:

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

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 ❑ 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

❑ Yes ❑ No Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

If **yes**, explain: ____

❑ Yes ❑ No Does your student understand how to avoid foods that cause allergic reactions?

What treatment or medication has your health care provider recommended for use in an allergic reaction?

____

❑ Yes ❑ No Have you used the treatment or medication?

❑ Yes ❑ No Does your student know how to use the treatment or medication?

Please describe any side effects or problems your student had in using the suggested treatment or medication.

____

____

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Food Allergy Assessment Form *(2020-2021)* ***(cont.)***

Student Last Name, First Name ______________________ **Birth Date** __________ **Grade** ______

If you intend for your child to eat school provided meals, have you completed and submitted a **Medical Statement for Student Requiring Special Meals** form for school?

- ☐ Yes
- ☐ No, I need to acquire the form, have it completed by a licensed health professional and return it to school.

If medication is to be available at school, have you submitted a **Permission for Prescription Medication** to school?

- ☐ Yes
- ☐ No, I need to acquire the form, have it completed by a licensed health professional and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies (in original packaging) to school?

- ☐ Yes
- ☐ No, I need to bring the medication/treatment to school and submit a **Permission for Prescription Medication** form 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

______________________________________ ______________________

Print Name of Licensed Health Professional (LHP) treating Food Allergy | Telephone Number

Signature of both Parents/Custodial Parent/Guardian | **Date of Signature**

______________________________________ ______________________

______________________________________ ______________________

Telephone Numbers:	**HOME**	**WORK**	**CELL**
Mother/Guardian	____________	____________	____________
Father	____________	____________	____________

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