**School Food Allergy Assessment Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap here to enter text. |  | Click or tap here to enter text. |
| Student Name |  | Date of Birth |  | Date |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Parent/Guardian |  | Phone/Cell |  | Work |

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 [ ]  Yes

(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 [ ]  Hen eggs

[ ]  Peanut products [ ]  Soy products [ ]  Cow's milk

[ ]  Sesame [ ]  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:

Click or tap here to enter text.

When was the last reaction? Click or tap here to enter text.

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:

Click or tap here to enter text.

What are the signs and symptoms of your student’s allergic reaction? *(Be specific; include things the student might say.)*

Click or tap here to enter text.

**Treatment**

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

[ ]  No [ ]  Yes, explain: Click or tap here to enter text.

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?

 Click or tap here to enter text.

Have you used the treatment or medication? [ ]  No [ ]  Yes

Adapted with permission from ESD 171 SNC

Does your student know how to use the treatment or medication? Self-administer? [ ] No [ ]  Yes

Please describe any side effects or problems your child had in using the prescribed treatment:

Click or tap here to enter text.

**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.

How can we help your student manage their allergy at school?

**Other**

**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

Will your student [ ]  buy lunch [ ]  bring lunch from home [ ]  both

Do you review the lunch menu if your student buys lunch? [ ]  Yes [ ]  No

Is your student involved in school sponsored after school activities/sports? [ ]  No [ ]  Yes

Please describe

Is there anything else school staff should be aware of?

Click or tap here to enter text.

**I give consent to share, with the classroom, that my child has a life-threatening food allergy.**

[ ]  Yes

[ ]  No

|  |  |  |
| --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap here to enter text. |
| Parent /Guardian Signature |  | Date |

|  |  |  |
| --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap here to enter text. |
| Reviewed by RN  |  | Date |

Adapted with permission from ESD 171 SNC Program