**Food Allergy Assessment Form**

Student Name: _____ Date of Birth: _____

Parent Name: _____ Phone: _____

Health care provider (name) treating food allergy: _____

Phone: _____

Do you **think** your child's food allergy may be **life-threatening**? ☐ Yes ☐ No

(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 ☐ 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 child had a reaction? ☐ Never ☐ Once ☐ More than once; please 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 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 child's allergic reaction? (Please be specific)

_____

_____

_____.

How quickly do the signs and symptoms appear after exposure to the food(s)?

_____ Seconds _____Minutes _____ Hours _____Days

**Treatment**

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

☐ No ☐ Yes; please explain:

_____

_____.

Does your child 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? ☐ Yes ☐ No

Does your child know how to use the treatment? ☐ Yes ☐ No

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

Parent Signature: _____Date: _____