



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

## Food Allergy Assessment Form (2022-2023)

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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:

- |  |   |                                |
|--|---|--------------------------------|
| <input type="checkbox"/> Peanuts               | <input type="checkbox"/> Fish/shellfish                             | <input type="checkbox"/> Eggs  |
| <input type="checkbox"/> Peanuts or nut butter | <input type="checkbox"/> Soy products                               | <input type="checkbox"/> Milk  |
| <input type="checkbox"/> Peanuts or nut oils   | <input type="checkbox"/> Tree nuts (walnuts, almonds, pecans, etc.) | <input type="checkbox"/> 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 (2022-2023) (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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_