



### Food Allergy Form

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell/work: \_\_\_\_\_

Health Care Provider (name) treating food allergy: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Did your student's **health care provider tell you** the food allergy may be **life-threatening**?  No  Yes

#### 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"/> Peanut or nut butter | <input type="checkbox"/> Soy products                               | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Peanut or nut oils   | <input type="checkbox"/> Tree nuts (walnuts, almonds, pecans, etc.) |                               |

Please list any others: \_\_\_\_\_

Circle How many times has your student had a reaction? Never Once More than once

If once or more than once, please explain: \_\_\_\_\_

When was the last reaction? \_\_\_\_\_

Are the food allergy reactions (Circle all that apply): staying the same getting worse getting better

#### Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? (Circle all that apply)

Eating foods Touching foods Smelling foods Other

If 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



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

If Yes, please 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 student 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 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.

**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.

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.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_