

# Food Allergy Information for School

Student Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Health Care Provider treating food allergy: \_\_\_\_\_ Phone: \_\_\_\_\_

Do **you think** your student's asthma may be **life-threatening**? ☐ No ☐ Yes

(If YES, please see the school nurse as soon as possible)

Does your student's **health care provider think** the asthma 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:

- |   |   |                               |
|---|---|-------------------------------|
| <input type="checkbox"/> Peanuts              | <input type="checkbox"/> Fish/shellfish                             | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Peanut or nut butter | <input type="checkbox"/> Tomato products                            | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Peanut or nut oil    | <input type="checkbox"/> Tree nuts (walnuts, almonds, pecans, etc.) |                               |
| <input type="checkbox"/> Other: _____         |   |                               |

How many times has your student had a reaction? ☐ Never ☐ Once ☐ More than once, explain: \_\_\_\_\_

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

Are the food allergy reactions: ☐ staying the same ☐ getting better ☐ getting worse

## **Triggers and Symptoms**

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

- |                                       |                                      |                                      |
|---------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Eat foods    | <input type="checkbox"/> Touch foods | <input type="checkbox"/> Smell foods |
| <input type="checkbox"/> Other: _____ |                                      |                                      |

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**

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

If YES, explain: \_\_\_\_\_

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?

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 student had in using the suggested treatment, if any:

**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 the school to do to help your student avoid problem foods?

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

RN signature \_\_\_\_\_ Date \_\_\_\_\_