

Colville School District
School Food Allergy Assessment Form

Click or tap here to enter text.

Student Name

Click or tap here to enter text.

Date of Birth

Click or tap here to enter text.

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

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.](#)

Parent /Guardian Signature

[Click or tap here to enter text.](#)

Date

[Click or tap here to enter text.](#)

Reviewed by RN

[Click or tap here to enter text.](#)

Date

Adapted with permission from ESD 171 SNC Program