School Food Allergy Assessment Form

Student Name _____

Date of Birth _____

Current Date _____

Parent/Guardian Name _____

Reachable Phone Number _____

Health Care Provider Treating the Allergy _____

Health Care Provider Phone Number_____

Do you think your child's food allergy is life-threatening? Yes No

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

History and Current Status

Circle 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.)	

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

Explain the reactions:

When was the last reaction?

Are the food allergy reactions: S taying the Same G etting Worse G etting Better

Triggers and Symptoms

What has to happen for your student to react to the problem foods? Check all that apply.

Eat the food Touch the food Smell the food Other, please explain:

What are the signs and symptoms of your student's allergic reaction? Be specific, include things student might say.

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

Seconds Minutes Hours Days

Treatment

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

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? Yes No

Does your student know how to use the treatment? Yes No

Please describe any side effects or problems your child had in using the suggested treatment:

Will your student eat meals at school? Yes No

If so, which meals? Breakfast Lunch Snack

Have you contacted Food & Nutrition Services about your student's allergy? Yes No

Is the school building nurse aware of your student's food allergy? Yes No

If medication is needed at school, has it been provided to the school nurse? Yes No

Is the classroom teacher aware of your student's allergy? Yes No

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 or Guardian Signature

Date

Please return this form to: tanner.lange@austin.k12.mn.us or Food & Nutrition Services, Room 105, Austin High School

For School Use:

School Building Nurse Reviewed:_____
Date:

Food & Nutrition Services Reviewed:_____ Date:

Form Updated: 8/2023