

## Celiac Disease Assessment Form

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

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

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

Do you think your child's celiac disease 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 celiac disease may be life-threatening?  
\_\_\_ No \_\_\_ Yes (If YES, please see the school nurse as soon as possible.)

### History and Current Status

Symptoms student has experienced:

<input type="checkbox"/> Bloating	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Constant unexplained fatigue
<input type="checkbox"/> Constipation	<input type="checkbox"/> Frequent headaches or migraines	<input type="checkbox"/> Itchy skin
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Loss of weight/underweight	<input type="checkbox"/> Gas and/or stomach cramping

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

When and how was your child first diagnosed with Celiac Disease? \_\_\_\_\_

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

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

Are the food reactions: \_\_\_ staying the same \_\_\_ getting worse \_\_\_ getting better

Does your child have any associated illnesses with the Celiac Disease?

<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Eczema or unexplained Dermatitis
<input type="checkbox"/> Nervous Stomach	<input type="checkbox"/> Lactose intolerance
<input type="checkbox"/> Anemia	Other: _____

## Triggers

Please list the foods or ingredients that will cause symptoms: \_\_\_\_\_

\_\_\_\_\_

What has to happen for your student to react to the problem food(s)?

\_\_\_\_\_

\_\_\_\_\_

What are the signs of your student's reaction? (Be specific; include things the student might say.)

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_ Seconds \_\_\_ Minutes \_\_\_ Hours \_\_\_ Days

## Treatment

Has your student ever needed treatment at a clinic or the hospital for a reaction?

\_\_\_ No \_\_\_ Yes, explain: \_\_\_\_\_

Does your student understand how to avoid foods that cause reactions? \_\_\_ Yes \_\_\_ No

What treatment or medication has your health care provider recommended for use in a 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 has 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?

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I give consent to share, with the classroom, that my child has Celiac Disease.

Yes

No

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by R.N.: \_\_\_\_\_ Date: \_\_\_\_\_