Lake Stevens School District
G3: Student Food Allergy Assessment Form

Instructions: To be completed by parent/guardian. Please answer all questions and sign & date the last page for this form to be complete. This is a two-page document. Thank you!

Student Name: ______________________________ **Date of Birth:** ________________

Parent/Guardian: ______________________ **Home Phone:** _______________ **Cell:** ________________________

Licensed Health Care Provider: ______________________________ **Phone:** ______________________

Allergist: ______________________________ **Phone:** ______________________

1. Health Concern

What is your child allergic to?

Peanuts Tree nuts Wheat Eggs Fish Shellfish Milk Soy Latex

May have baked goods with small amount of eggs Other: ____

Did your LHP diagnose this condition as:

a) life-threatening food allergy?

No Yes, food: ____

b) non-life-threatening food allergy?

No Yes, food: ____

c) food intolerance?

No Yes, food: ____

Has your LHP prescribed your child an epinephrine auto injector (EpiPen)?

No Yes (if yes, please see option B on page 2 of 2)

Does your child have a current diagnosis of asthma?

No Yes

Does your child have a prescribed inhaler?

No Yes

2. History & Current Status

Age of student when allergy was first discovered: _________

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

Date of last reaction: ________________ Please describe reaction: ____

3. Triggers and Symptom

What are the early signs and symptoms of your student's allergic reactions? (Please be specific and include things they might say.)

____

How does student communicate his/her symptoms?

____

How quickly do symptoms appear after exposure to food(s)?

_____ seconds _____ minutes _____ hours _____ days

Please check all symptoms that student has experienced in the past:

Skin:	Hives	Itching	Rash	Flushing	Swelling (face, arms, hands, legs)
Mouth:	Itching	Swelling (lips, tongue, mouth)			
Abdominal:	Nausea	Cramps	Vomiting	Diarrhea	
Lungs:	Shortness of breath		Repetitive cough	Wheezing	
Throat:	Itching	Tightness	Hoarseness	Cough	
Heart:	Weak pulse	Loss of consciousness			

4. Treatment

How have past reactions been treated? ____

How effective was the student's response to treatment? ______________________________________

Was there an emergency room visit? If yes, explain. No Yes: ______________________________

Was the student admitted to the hospital? If yes, explain. No Yes: ______________________________

5. School Meals

Will student eat school breakfast or lunch? Daily Occasionally Never

Do you have any concerns about student self-selecting food and beverages offered in school cafeteria? If yes, explain:

No Yes: ____

Would you like to request dietary accommodations?

No > Food Service will not be alerted, and student will continue to self-select food and beverages without restrictions.

Yes > Further documentation is needed. Please complete the "C6: Request for Special Dietary Accommodations" form. Please note, this document requires a LHP signature.

Seating options: Food allergy table Parchment paper barrier on table Student may self-select seat location

Please check the appropriate box below:

A. Non-Life-Threatening	**B. Life-Threatening**
Student with "non-life-threatening" food allergy or intolerance will continue to self-select food items at breakfast or lunch, unless a "C6: Request for Special Dietary Accommodations" form has been completed and is on file in the health room office. Please note, this document requires a LHP signature.	A "G1: Severe Allergy Medication Order" form must be completed and on file in the health room office. Please note, this document requires a LHP signature.

I authorize the school nurse to share any information provided in this assessment form with my child's healthcare provider.

Parent/Guardian signature: ____________________________________ Date: ____________________

School RN Signature: ____ Date: ____________________

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