

Student: _____ Birthday: _____

School: _____ Grade: _____ Date: _____

Information collected from this form will UPDATE the nurse on your student's health condition for the purpose of school planning. Once completed, return this form to your school nurse. If your student's allergy is not food-related, skip questions related to food.

 If your student NO LONGER requires an EpiPen for this allergy, you must submit a healthcare provider note to the school nurse in order to discontinue their school health plan and medication. If this applies to you, check YES here:

1. What is your student allergic to? Peanuts Tree Nuts Wheat* Whole Egg* Egg in baked products*
 Milk/Dairy* Soy* Sesame* Fish Shellfish Latex Bee/Insect Stings Other: _____
 (*means a Dietary Prescription Form is Indicated)
2. In the past year, has anything changed regarding the allergy (i.e. new or resolved allergies, change in symptoms, change in medication, new allergy testing, etc.)? No Yes: _____

3. When and where was your student's last allergy testing? _____
4. Has your student had any allergic reactions in the past year? No Yes, describe (Be specific: When was it? How quickly did the reaction occur? Symptoms? What did you do? Did it require medical care?): _____

5. Over time are reactions: Staying the same? Getting better? Getting worse? No new reactions
6. Has your student reacted to allergen by: Eating/Ingesting food Touching food Smelling/Inhalation of food
7. If your student has environmental or seasonal allergies, what are they? N/A: _____
 Do they take allergy medication? No Yes, what (Daily & as needed): _____

8. INDEPENDENCE: Does your student:

Know what their allergy is?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Know how to read food labels and determine if a food is allergen-free?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Independently avoid foods that cause allergic reactions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Does your student require Allergy Aware Seating in Cafeteria/Classroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Know not to share or trade food/utensils?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Know to tell an adult if they've had an exposure or are experiencing symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Know how to self manage an allergic reaction (5th grade and above) (*Requires medication order and authorization from nurse, parent and health provider.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

9. Food related:
- A. Will your student: Only bring food from home Purchase school meals Combination of home and school meals
 Requires Stop Purchases (no school meals allowed)
- B. Do you review the lunch menu monthly if your student buys school meals? No Yes
10. School-Sponsored Activities & Field Trips:
- Will your student be involved in school-sponsored activities, events, or sports outside the school day? No Yes
 - If YES, what? _____

11. Transportation:
- When riding the bus to or from school or on field trips should your student sit up front close to the driver? No Yes

12. List Emergency Contacts for your student:

Name	Relationship	Phone Number	Phone Number
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13. List primary care provider and specialists involved in your child's care:

Physician	Type of Provider	Date Last Seen	Phone

14. Does your student have health insurance? No Yes, which one? _____

15. Are you having challenges getting allergy medication or connecting with a doctor? No Yes

Parent/Guardian Signature & Relationship Date Email address