



Wausau School District Food Allergy and Intolerance Questionnaire

Student name: _____ Date of birth: _____

Parent/guardian: _____ Date: _____

Allergist or Primary Care Provider: _____

Name of Clinic: _____

Has your child been diagnosed with a food allergy or intolerance by a healthcare provider?

Age of child at diagnosis: _____

History and Current Status:

1. Type of allergen or intolerance:

Peanuts Tree nuts (walnuts, pecans, etc.) Eggs Milk Wheat Soy Fish Shellfish

Other: _____

2. When was your child's most recent reaction? _____

3. The food reaction happens when my child is exposed to:

Fresh foods Cooked or baked foods containing the food ingredient

Other - Describe: _____

4. What type of exposure is necessary for an allergic reaction? Ingestion Contact Inhalation

Symptoms:

1. What are the symptoms of your child's food allergy or intolerance? (Be specific; include things your child might say.)

2. How quickly do symptoms appear after exposure or ingestion? _____

Treatment

- 1. How have past reactions been treated? _____
- 2. What treatment or medication has your healthcare provider recommended to treat a reaction?

School Accommodations

- 1. My child needs to sit at a “safe” table for lunch? No Yes
- 2. My child may eat food from a package with a label that says “may contain” or “has been processed in the same facility” as their allergen. No Yes
- 3. I would like to be contacted before my child has a treat from a package with a label that says “may contain” or “has been processed in the same facility” as their allergen. No Yes

Self-Care

Does your child:

- Know what foods to avoid? No Yes
- Ask about food ingredients? No Yes
- Read and understand food labels? No Yes
- Tell an adult immediately after an exposure? No Yes
- Tell peers and adults about the allergy? No Yes
- Firmly refuse a problem food? No Yes

Please add any additional information that would be helpful for school personnel to know about your child’s food allergy/intolerance:

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