

G3: Student Food Allergy Assessment Form*(Parent/guardian to complete)*

Instructions: 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**

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.

☐ **B. Life-Threatening**

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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