

Student: _____ Birthdate: _____ School: _____ Grade: _____ Date: _____

The following information will help the nurse in determining any special needs for your student at school. Once completed, return this form to your school nurse. If your student's allergy is not food-related, skip questions related to food.

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. Did your student's healthcare provider tell you this allergy could be life-threatening? NO YES
 3. Has your student been prescribed an EpiPen? NO YES
 4. Has your student had allergy testing? NO YES, when & where: _____
 5. **Does your student have asthma?** NO YES, triggers: _____
 Do they have prescribed asthma medicine? NO YES, what (daily & as needed): _____
 6. Does your student have environmental or seasonal allergies? NO YES, to what: _____
 Do they take allergy medication? NO YES, what (daily & as needed): _____

Food Related

7. Will your student: Only bring food from home Purchase school meals Combination of home and school meals
 Requires Stop Purchases (no school meals allowed)

Reaction History

8. **Has your student reacted to allergen by:** Eating/Ingesting food Touching Food Smelling or Inhalation of Food
 9. How old was your student when the allergy was first discovered? _____
 10. How many times has your student had a reaction? Never Once More than once: _____
 Date of last reaction: _____
 11. How soon did reaction occur after contact with allergen? Seconds Minutes Hours Days Unknown
 Other: _____
 12. Please describe reaction (be specific, early and late signs/symptoms, time from exposure, etc.): _____

 13. Did you give medication? NO YES, what? _____
 Did medication resolve the reaction? YES NO, explain: _____
 14. **Has an EpiPen been given before?** NO YES, how many doses were given before symptoms resolved? _____
 15. **Has your student ever needed treatment at a clinic or hospital for an allergic reaction?** NO YES, describe:

 16. Over time are reactions: Staying the same Getting better Getting worse Unknown

Food Independence at School/Allergy management at School

17. 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 reaction?	<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

Care Coordination

18. List primary care provider and specialists involved in your child's care:

Physician	Type of Provider	Date Last Seen	Phone

19. Does your student have health insurance? NO YES, which one? _____

20. Are you having challenges getting allergy medication or connecting with a doctor? NO YES

21. Is your student involved in school-sponsored activities or sports outside the school day?

NO YES*, what? _____

22. For elementary: Do we have your permission for students in the classroom to know of this allergy? NO YES

23. **When riding the bus to or from school or on field trips should your student sit up front close to the driver?** NO YES

24. List emergency CONTACTS for your student

(Name) (Relationship)	(Phone Number)	(Phone Number)
(Name) (Relationship)	(Phone Number)	(Phone Number)

School Planning

Allergy to:	Severity:	Symptoms:	Notes
	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Life-Threatening	<input type="checkbox"/> Itching <input type="checkbox"/> hives <input type="checkbox"/> rash <input type="checkbox"/> tingling <input type="checkbox"/> swelling, where: _____ <input type="checkbox"/> cough <input type="checkbox"/> wheeze <input type="checkbox"/> hoarseness <input type="checkbox"/> difficulty breathing <input type="checkbox"/> dizziness <input type="checkbox"/> nausea <input type="checkbox"/> cramps <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> eczema <input type="checkbox"/> other: _____	
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Parent/Guardian Signature & Relationship

Date

Email Address