North Beach School District #64
Ocean Shores Elementary (360) 289-2147/Pacific Beach Elementary (360) 276-4512
North Beach Junior/Senior High School (360) 289-3888

Food Allergy Assessment Form

Student Name: ______________________________________________ Date of Birth: __________ Date: __________

Parent/Guardian: _______________________________________ Phone: ___________________ Cell/Work: ___________

Health Care Provider (name) treating food allergy: ________________________ Phone: ______________

Do you think your child's food allergy may be life-threatening? □ No  □ Yes
(If YES, please see the school nurse as soon as possible).

Did your student’s health care provider tell you the food allergy may be life-threatening? □ No  □ Yes
(If YES, please see the school nurse as soon as possible).

History and Current Status

Check the foods that have caused an allergic reaction:

☑ Peanuts       ☐ Fish/shellfish       ☐ Eggs
☑ Peanut or nut butter ☐ Soy products ☐ Milk
☑ Peanut or nut oils ☐ Tree nuts (walnuts, almonds, pecans, etc.)

Please list any others: ________________________________________________________________

How many times has your student had a reaction? □ Never  □ Once  □ More than once, explain: ___________

When was the last reaction? __________________________

Are the food allergy reactions: □ staying the same  □ getting worse  □ getting better

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? (Check all that apply)

☑ Eating foods   ☐ Touching foods   ☐ Smelling foods   ☐ Other, please explain: _______________________

What are the signs and symptoms of your student’s allergic reaction? (Be specific; include things the student might say.)

_____________________________________________________________________________________

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

_____ Seconds  _____ Minutes  _____ Hours  _____ Days

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

☐ No   ☐ Yes, explain: _______________________

Does your student understand how to avoid foods that cause allergic reactions?  ☐ Yes  ☐ No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

_____________________________________________________________________________________

Have you used the treatment? ☐ No  ☐ Yes
Does your student know how to use the treatment?  □ No  □ Yes
Please describe any side effects or problems your child had in using the suggested treatment:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

If you intend for your child to eat school provided meals, have you filled out a diet order form for school?

□ Yes.
□ No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is to be available at school, have you filled out a medication form for school?

□ Yes.
□ No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies to school?

□ Yes.
□ No, I need to get the medication/treatment and bring it to school.

What do you want us to do at school to help your student avoid problem foods?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

I give consent to share, with the classroom, that my child has a life-threatening food allergy.

□ Yes.
□ No.

Parent/Guardian Signature: ____________________________ Date: ______________

Reviewed by R.N.: ____________________________ Date: ______________