NCS Food Allergy Assessment Form

School Year: Grade:

Student Name: Date of Birth:

Parent/Guardian:

Best Contact Number: Alternate Phone:

Health Care Provider (name) treating food allergy:

Phone:

Do you think your child's food allergy may be life-threatening? ☐ No ☐ Yes

Did your student's health care provider tell you the food allergy may be life-threatening?
☐ No ☐ Yes

History and Current Status

Check the foods that have caused an allergic reaction:

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

Please list any others:

How many times has your student had a reaction?

☐ Never ☐ Once ☐ More than once, explain:

When was the last reaction (date)?

Are the food allergy reactions:
☐ Staying the same ☐ Getting worse ☐ Improving

Triggers and Symptoms

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

☐ Eating/Ingesting the food ☐ Touching the food ☐ Smelling the food

☐ 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?
☐ No ☐ Yes

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 medication is to be available at school, an Authorization for Medication form needs to be completed by your health care provider, and return it to school along with the medication. These forms will need to be completed each year and/or resubmitted if any changes in care are requested by the health care provider or parent. Additionally, if an Epi Pen is required, we ask that two be available at school if possible.

Please remember it is important to update the school office should your child's allergy information change. Thank you!

Parent/Guardian Signature:

Date: