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 contact 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 contact 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/Inhaling 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

Adapted from OSPI Anaphylaxis Guidelines

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 RN: _____ Date: _____

Adapted from OSPI Anaphylaxis Guidelines

Medical Statement for Student Requiring Special Meals

Name of Student:	School District:
Birth Date:	School Attended:
Parent Name:	Telephone:
Telephone:	

For Physician's Use

Identify and describe disability, or medical condition, including allergies that requires the student to have a special diet. Describe the major life activities affected by the student's disability (see back of form).

_____

_____

_____

Diet Prescription (check all that apply):

☐ Diabetic (include calorie level or attach meal plan) ☐ Modified Texture and/or Liquids
☐ Reduced Calorie ☐ Food Allergy (describe): _____
☐ Increased Calorie ☐ Other (describe): _____

Food Omitted and Substitutions:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

OMITTED FOODS	SUBSTITUTIONS
_____	_____
_____	_____
_____	_____

Indicate Texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Indicate thickness of liquids:

☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

☐ **Special Feeding Equipment** _____

Additional comments: _____

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

_____	_____	_____
Physician's Signature	**Telephone Number**	**Date**
_____	_____	_____
Signature of Preparer or Other Contact	**Telephone Number**	**Date**

I hereby give my permission for the school staff to follow the above stated nutrition plan.

_____	_____
Parent/Guardian	**Date**

Revised 6/99

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. **Asthma:** [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE STUDENT'S PICTURE HERE

For a suspected or active food allergy reaction:

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of mild or severe symptoms from different body areas.

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. **Use Epinephrine.**

⇩ ⇩ ⇩

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Request ambulance with epinephrine.

- Consider giving additional medications (following or with the epinephrine):
  - » Antihistamine
  - » Inhaler (bronchodilator) if asthma
- Lay the student flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport student to ER even if symptoms resolve. Student should remain in ER for 4+ hours because symptoms may return.

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/discomfort

⇩ ⇩ ⇩

1. **GIVE ANTIHISTAMINES, IF ORDERED BY PHYSICIAN**
2. Stay with student; alert emergency contacts.
3. Watch student closely for changes. If symptoms worsen, **GIVE EPINEPHRINE.**

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

_____

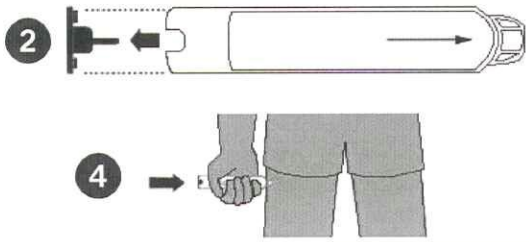
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 8/2013

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

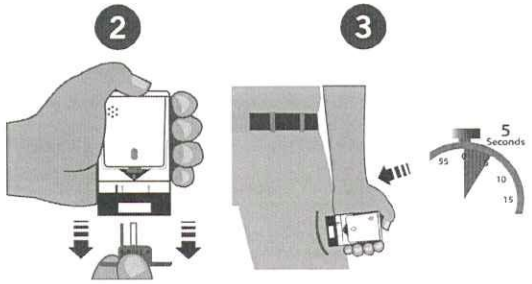
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat student before calling Emergency Contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____

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