kids first
LEARNING CENTER

FOOD ALLERGY ASSESSMENT FORM
THIS FORM MUST ACCOMPANY A MEDICAL PLAN OF ACTION FORM FROM YOUR CHILD'S PEDIATRICIAN

Student Name: _____ Date of Birth: _____ Date: _____

Parent/Guardian: _____ Phone: _____|

Health Care Provider treating food allergy: _____ Phone: _____

Did your child's **health care provider tell you** the food allergy may be **life-threatening**? ___No ___Yes

History

Circle the foods that have caused an allergic reaction:

Peanuts Peanut or nut butter Peanut or nut oils Fish/Shellfish Egg Dairy

Tree nuts (walnuts, almonds, pecans, etc.) Soy products Please list any others: _____

How many times has your child 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 child to react to the problem food(s)? *(circle all that apply)*
Eating food(s) touching food(s) smelling food(s) Other, please explain: _____

What are the signs and symptoms of your child's allergic reaction? *(Be specific)*

_____

How quickly do the signs and symptoms appear after exposure to the food(s)? __ Seconds___ Minutes___ Hours___ Days

Treatment

Has your child ever needed treatment at a clinic or hospital for an allergic reaction to food? __No __Yes, explain:

_____

Does your child 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

I agree to provide Kids First Learning Center with the food allergy medication prescribed by a health care provider while my child is at school.

_____ _____
Signature Date