Seattle Public Schools

FOOD ALLERGY ASSESSMENT FORM FOR SCHOOL

Student's Name: ______________________________ **School Year:** ____________

Date of Birth: ____________ **Grade:** _____ **School :** ______________________________

Diagnosis

Check the food(s) that your student is allergic to:

☐ Peanut ☐ Fish ☐ Egg ☐ Wheat ☐ Milk
☐ Tree Nut ☐ Shellfish ☐ Soy ☐ Sesame ☐ Other ______________

Did your student's **health care provider diagnose** the food allergy/allergies as:

- life-threatening * ☐ No ☐ **Yes*,** food(s)______________________________
- not life-threatening ☐ No ☐ Yes, food(s) ______________________________
- a food intolerance ☐ No ☐ Yes, food(s) ______________________________
- other ☐ No ☐ Yes (If Yes, describe) ______________________________

***If life-threatening, MUST contact school nurse** - *See definition of life-threatening at the bottom of this form*

Has your student's health care provider prescribed an epinephrine auto-injector (AUVI-Q, EpiPen, SYMPJEPI, Adrenaclick, other)?

☐ No ☐ Yes* (**If Yes, contact the school nurse for required forms**)

Has your student's health care provider prescribed an antihistamine (Benadryl, Zyrtec, Claritin, other)?

☐ No ☐ Yes

History and Current Status

How many times has your student had an allergic reaction? ☐ Never ☐ Once ☐ More than once, explain:

____

Date of last reaction: ____________________

Check the box that best describes your student's food allergy reactions:

☐ staying the same ☐ getting worse ☐ getting better

Symptoms (check each box that describes your student's symptoms)

☐ MOUTH—Itching, tingling, or swelling of the lips, tongue, or mouth

☐ THROAT—Tight or hoarse throat, trouble breathing or swallowing

☐ LUNG—Shortness of breath, repetitive coughing, and/or wheezing

☐ GENERAL—Panic, sudden feeling of impending doom

☐ SKIN—Hives, itchy rash, and/or swelling about the face or extremities

☐ GUT—Nausea, stomachache/abdominal cramps, vomiting and/or diarrhea

☐ HEART—"Thready" pulse, "passing out", fainting, blueness, pale

☐ OTHER—______________________________________

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

____

How quickly do symptoms appear after exposure to the food allergen? (seconds, minutes, hours, days)

____

Treatment

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

☐ No ☐ Yes, explain: ____

Has your student ever needed to use an epinephrine injector to treat an allergic reaction? ☐ Yes ☐ No

Does your student understand how to avoid food(s) that cause allergic reactions? ☐ Yes ☐ No

School Meals

Will your student eat meals provided by Seattle Public Schools (breakfast or lunch)?

☐ No. If no, my student will **NEVER** eat meals provided by Seattle Public Schools.

☐ Yes. **If yes, continue below.**

My student's food allergy or intolerance is **NOT** life-threatening. **Select the appropriate special dietary accommodation response:**

- ☐ I am **NOT** requesting a special dietary accommodation for my student. My student will self-select food items without restriction.
- ☐ I am requesting a special dietary accommodation. (Contact School Nurse for Dietary Form)

OR

☐ My student's food allergy **IS** life-threatening*

Students with a known life-threatening food allergy must provide the school with a Severe Allergy/Anaphylaxis Medication Order and prescribed medication, if indicated, before the first day of each school year in order for the student to attend school. Special dietary orders indicated on the plan will be provided with a health care provider's signature.

____ ______________________

Parent/Guardian Signature Date

____ ______________________

Reviewed by Registered Nurse Date

*Prior to attendance at school, each child with a life-threatening health condition shall present a medication or treatment order addressing the condition. A life-threatening health condition means a condition that will put the child in danger of death during the school day if a medication and/or treatment order and a nursing plan are not in place. Following submission of the medication or treatment order, a nursing plan shall be developed by the school nurse. Medication and treatment orders are required to be completed each school year. Students with a life-threatening health condition will be referred to the 504 Team for evaluation. (WAC 392-380-045, RCW 28A.210.320, SPS Superintendent Procedure 3413SP)