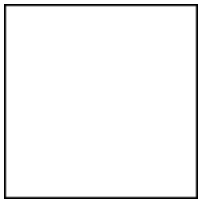
Allergy Assessment Form



Date: _____

Student's Name: _____ Birth date: _____ Teacher/Grade ____

Allergy to: _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W) _____ (C) _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W) _____ (C) _____

Physician child sees for Allergies: _____

Phone: _____ Fax: _____

Allergy Health History

1. Identify the signs and symptoms exhibited by your child during an allergic reaction:

____Rash	____Hives/Welts	____Stomach ache or cramping
____Itching	____Sensation of warmth	____Diarrhea
____Dizzy/Faint	____Headache	____Lightheaded
____Nasal Congestion	____Runny Nose	____Wheezing
____Shortness of breath	____Sneezing	____Throat tightening
____Chest discomfort	____Coughing	____Difficulty swallowing
____Difficulty breathing	____Nausea/Vomiting	____Other: _____
____Swelling of tongue, eyelids, face		

2. Rate the severity of the allergic reaction: ____Mild ____Moderate ____Severe
3. Reaction caused by: ____Ingestion ____Contact ____Inhalation _____Bite/Sting
4. Is there a history of an anaphylactic reaction? ____Yes ____No

   Describe: _____
5. When was this allergy discovered? _____
6. When was the last evaluation your child had for allergies? _____
7. Does your child have a history of asthma? ____Yes ____No If you answered yes, then please answer the following questions:

   Does your child use bronchodilators (inhalers)? ____ Yes ____No

   Does your child use medication at night or upon awakening in the morning? ____Yes ____No
8. Does your child recognize his/her allergic reaction? ____Yes ____No
9. Does your child know what to do if he/she is having an allergic reaction? ____Yes ____No

Turn Form Over

If your child's allergy is not triggered by food please skip ahead to item 17.

10. Is your child able to visually recognize the allergen in all its different forms (ex: peanut; peanut butter, peanuts, etc.) or part of another food (ex: peanut butter cookie)? ____Yes ____No
11. Is your child able to read labels for the offending allergen? ____Yes ____No
12. Are there any other specific foods your child should avoid? _____
13. Does your child know to eat only food brought from your home? ____Yes ____No
14. Does your child know not to trade or take food from classmates and adults? ____Yes ____No
15. Does your child understand that a safe food may become cross-contaminated? ___Yes ___No
16. Will your child need to eat at an allergen free lunch table? ____Yes ____No

17. Will your child take medication regularly or on an "as needed" basis for this allergy? ___Yes ___No

Please list all current medications below:

Medication Name	Route	Dosage	Time	At Home or School

19. In the event of an allergic reaction, does your child require epinephrine? ____Yes* ____No
20. Will your child carry their emergency medication at school? ____Yes ____No
21. Does your child have a medical alert bracelet? ____Yes ____No

Parent/Legal Guardian Signature _____ Date _____

***Parents/Guardians are responsible for supplying necessary medication(s) to the school and completing an "Authorization for Medication Administration" annually. Depending on your child's particular allergy &/or medication needs, additional forms may be required.**

5-2012