# Ft. Zumwalt School District

## FOOD ALLERGY ASSESSMENT FORM

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

Parent/Guardian:_____Phone:_____Cell/Work_____

Physician's name_____ Phone:_____

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

Did your child's doctor tell you the food allergy may be life-threatening? Yes No

**If yes to either question above, please have your doctor fill out and sign this form, a Food Allergy Action Plan and any medication permission forms needed.**

**History and Current Status**

Type of Food Allergy_____

Has Allergy testing been completed? ____yes _____no If yes, date_____

Classification: Mild Moderate Severe

How many times has your child had a reaction? ___Never _____Once _____More than once

Date and description of episode (s):

_____
_____
_____

Was the allergic reaction treated at a clinic or hospital? If yes, explain:_____

_____

**Triggers and symptoms**

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

___eating foods ____touching foods ____smelling/inhaling foods _____other, please explain

_____

What are the signs and symptoms of your child's allergic reaction? How quickly do the symptoms appear after exposure? Be specific, include things child might say.

_____
_____
_____

Does your child understand how to avoid food that cause allergic reactions? ____Yes _____No

**Recommendations for School:**

***All accommodations must have a physician's signature to verify necessity of accommodations**.

*Special food requirements: **Yes** **No** If yes: _____

*Special classroom accommodations: **Yes** **No** If Yes: _____

_____

*Special lunchroom seating: **Yes** **No** If yes: _____

_____

**Classroom/school parties, birthday treats and snacks, food treats will be handled as follows:**

_____Parent supplies all snacks and treats for student stored in classroom

_____Parent provides "safe snack" list to be shared with classroom parents

**Field trips – All treatment supplies are taken and care is provided:**

_____By accompanying parent

_____By school staff trained in student's emergency action plan

Before and after school activities: _____

**Activities student can self-manage:**

**_____**Will not trade food with others

_____Will not eat anything with unknown ingredients or known allergen

_____Will notify adult immediately if eats something they believe may contain allergen

**You must submit the proper medication forms to keep any medication at school and supply the school with the medication needed.**

Date: _____

Physician's signature_____ Telephone: _____

Physician's Name: _____

Parent's Signature_____

**Neither the Ft. Zumwalt School District, nor its school personnel, shall be responsible for diagnosing and determining food allergies and/or those foods or ingredients in foods that are safe for a student with an identified food allergy to consume.**