EDUCATION FRANCAISE GREATER SEATTLE

FOOD ALLERGY ASSESSMENT FORM

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

Date of Birth: ______________ **Classroom:** _____

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:**

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

☐ No ☐ Yes* (**If Yes, you must talk to Lisa Foret in person in addition to this form)**

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

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My student may carry and self-administer prescribed EAI (Epinephrine auto-injector) Yes No

My student may need to be administered another type of medication, which he will carry: Yes No

Name of the Medication: ____

Describe indications:____

Is the student authorized to self- administer : Yes No

Authorization

- I understand that the medication may be administered by a member of the EFGS staff if the student is not in capacity of self administering the medication.
- Student is encouraged to wear a medical ID bracelet identifying the medical condition
- I release EFGS staff from any liability in the administration of this medication during EFGS hours. By law, my signature indicates that I shall hold harmless and indemnify EFGS staff against all claims, judgments or liability arising out of self-administration and self carrying of medication by my student.

______________________________________ ______________________

Parent/Guardian Signature Date