Lind- Ritzville Schools
Allergy Assessment Form

Student Name: _____ Grade: _____ Date of birth: _____ Date: _____

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Health Care Provider treating allergy: _____ Phone: _____

Did your child's **health care provider tell you** the allergy may be **life-threatening**?.. ☐ No ☐ Yes
(If YES, please call the school nurse as soon as possible)

History and Current Status

Check the items that have caused an allergic reaction:

☐ Peanuts	☐ Fish/shellfish	☐ Eggs
☐ Peanut or nut butter	☐ Soy products	☐ Milk
☐ Peanut or nut oils	☐ Tree nuts (walnuts, almonds, pecans, etc.)	☐ Bees, other insects

Please list any others: _____

How many times has your child had a reaction? ☐ Never ☐ Once ☐ More than once, explain: _____

_____

When was the last allergic reaction? _____

Are the allergic reactions: ☐ staying the same ☐ getting worse ☐ getting better

Does your child have eczema or other skin related problems? ..... ☐ No ☐ Yes
Does your child have asthma? ..... ☐ No ☐ Yes
Does your child use medications for his/her asthma? ..... ☐ No ☐ Yes
What medications is he/she using for their asthma? _____

Triggers and Symptoms

What has to happen for your child to react to the problem allergen(s)? *(Check all that apply)*
☐ Eating foods ☐ Touching foods ☐ Smelling foods ☐ Bite/Sting ☐ Other, explain:

_____

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

_____

_____

How quickly do the signs and symptoms appear after exposure to the allergen(s)?
_____ Seconds _____ Minutes _____ Hours _____ Days

Treatment

Has your child ever needed treatment at a clinic or the hospital for an allergic reaction?
☐ No ☐ Yes, explain: _____

Does your child understand how to avoid items that cause allergic reactions? ..... ☐ Yes ☐ No

What treatment or medication has your Health Care Provider recommended for use in an allergic reaction?

_____

_____

Have you used the treatment? ..... ☐ No ☐ Yes

Does your child know how to use the treatment? ..... ☐ No ☐ Yes

- Please describe any side effects or problems your child had in using the suggested treatment:

_____

If you intend for your child to eat school provided meals, have you filled out a diet order form for school?

☐ Yes.
☐ No, I need to get the form, have it completed by our physician and return it to school.
☐ N/A, Allergy is to insect, animal, or other.

If medication is to be available at school, have you filled out an Individual/Emergency/Medication Order/504 Care Plan for school?

☐ Yes.
☐ No, I need to get the form, have it completed by our health care provider and return it to school.

If medication is needed at school, have you brought the medication/ treatment supplies to school?

☐ Yes.
☐ No, I need to get the medication/treatment and bring it to school.

What do you want us to do at school to help your child avoid problem foods or allergens?

ADDITIONAL COMMENTS:

State law requires all students with life-threatening health conditions are to have medication or treatment orders, a nursing care plan, and staff training completed prior to attending school each year.

Parent/Guardian Signature _____ Date: _____

Reviewed by R.N. _____ Date: _____