FOOD ALLERGEN INFORMATION

Student Name:	DOB:	Today's Date:

You have listed in the Health History Form that your child has a food allergy. In order for the school personnel to respond quickly and effectively, additional information concerning your child's allergies would be helpful. Please take time to answer the following questions below.

Please indicate the type of food allergy:

☐Peanuts and peanut products
☐Tree nuts (_____)
☐Eggs
☐Cow's milk products/ Dairy
☐Soybeans or soy products
☐Wheat
☐Fish
☐Corn
☐Shellfish
☐Environmental:_____
☐Bananas
☐Insect:_____
☐Sesame Seeds/ Sesame products
☐Other:_____
☐Grass
☐Other:_____

Please check the following symptoms which you have observed when your child has had an allergic reaction:

☐Itchy or swelling of lips, tongue or mouth
☐Redness to face, cheeks, lips, ears
☐Nasal congestion
☐Runny nose, sneezing, sniffling
☐Itching or sense of tightness in the throat
☐Difficulty breathing, shortness of breath or wheezing
☐Repetitive coughing
☐Diarrhea
☐Hoarseness
☐Nausea / Vomiting
☐Abdominal cramps
☐Hives, itchy, red skin rash
☐Swelling of face or extremities
☐Shock
☐Dizziness or fainting
☐Unconsciousness
☐Difficulty swallowing or choking
☐Other:_____

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When was the date of your child's last allergic reaction? _____

How long after eating the allergic food did you child develop symptoms?
☐Immediately
☐Within 15-20 minutes
☐Within an hour
☐Longer than one hour (specify time)_____

Has your child ever needed to use an Epi-Pen? ☐Yes ☐No

If so, please explain when and why?
_____
_____
_____

Has your child been hospitalized (emergency room) for food allergy reactions? ☐Yes ☐No

Would you like your child to sit at our peanut-free table? ☐Yes ☐No

Does your child know how to avoid these foods and their by-products? ☐Yes ☐No

I understand and agree that by declining to have my child sit at a peanut/tree nut free table, no additional precautions will be taken in the cafeteria for other tables/areas to restrict peanut/tree nut products, and my child will be solely responsible for his/her management of exposure to the allergens.

Will medication be kept at school? ☐Yes ☐No
If yes, complete the medication consent form (Authorization to Administer Medication) available from the school nurse.

You will immediately be notified in the event of any possible allergic reaction. This information will be sharted with only those who have a need to know.

Parent Signature_____ Date:_____