World Youth Foundation, Inc.
Food Allergy Assessment Form

Student Name: ___________________________________ Date of Birth: __________Date:____________

Parent/Guardian: ____________________________Phone:_______________Cell/work:_________________

Health Care Provider (name) treating food allergy: ____________________________Phone:_____________

Do **you think** your child's food allergy may be **life-threatening**? __ No __ Yes
(If YES, please explain)

Did your child's **health care provider tell you** the food allergy may be **life-threatening**? __ No __ Yes
(If YES, please explain)

History and Current Status

Check the foods 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.)

Please list any others: ____

How many times has your student had a reaction? __Never __ Once __More than once
Explain:

When was the last reaction? _____________________

Are the food allergy reactions: ___ staying the same ___ getting worse ___ getting better

Triggers and Symptoms

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

___Eating foods ___ Touching foods ___ Smelling foods ___ Other, please explain:

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

How quickly do the signs and symptoms appear after exposure to the food(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 foods 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:

I give consent to share, with volunteers and mentors, that my child has a life-threatening food allergy.
____ Yes
____ No

Parent/Guardian Signature: __________________ Date: ________________