Food Allergy Assessment

Student ________________________________
Date ________________________________

Subjective:
What foods have caused a reaction for this student:

Will the student react when food:
- [ ] Eaten
- [ ] Touched
- [ ] Smelled
- [ ] In the same room with food

Signs and symptoms when reaction occurs (what are some things the student might say):

How quickly do the signs occur after exposure: _____ seconds _____ minutes _____ hours _____ days

How many times has a reaction occurred:
When was the last reaction:

Describe the worst reaction:

Are the reactions:  
- [ ] Staying the same
- [ ] Getting worse
- [ ] Not changing

Relating to this allergy, has the student ever needed:
- [ ] ER visit
- [ ] 911 call

What precautions does the student take to avoid a reaction:
What treatment has your health care provider recommended:

Has the treatment been used before
- [ ] yes
- [ ] no

If so, any side effects or problems with the treatment:

How should a reaction be handled at school:

Objective:
- [ ] EpiPen trainer demonstrated by student

Assessment:
- [ ] Risk of severe allergic reaction to ____________________________
- [ ] Student capable of carrying medication responsibly when at school and on the bus.
- [ ] Student capable of self-administering medication.

Plan:
- [ ] Reviewed correct EpiPen use.
- [ ] Reviewed student role when has a food allergy reaction at school.

Medication authorization:
- [ ] on file with signatures of health care provider and parent
- [ ] Dr. ______________________ office requested to fax med authorization
- [ ] Parent will call doctor’s office to request med authorization

- [ ] Emergency Care Plan (ECP) developed and distributed to parent for signature, health room, bus supervisor, PE/Athletic Director and ____________________________
- [ ] Parent contact:

_____________________________________
RN signature

NCESD rev 8/24/06 Assessment food allergy