Food Allergy History Form

Name: ___________________________ D.O.B.: ____________ Teacher: ___________________

Allergy to: ____

- Is your child asthmatic? ☐ Yes** ☐ No **Higher risk for severe reaction
- Does your child react to cross-contamination? ☐ Yes ☐ No
- Does your child react to air-borne contamination? ☐ Yes ☐ No
- When and how did you first become aware of the allergy?

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- When was the last time your child had a reaction?

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- Please describe the signs and symptoms of the reaction:

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- What type of medical treatment should be provided for your child?
  ☐ Epinephrine ☐ Antihistamine ☐ Other: (please list) _________________
- Does your child require an allergen-free eating area? ☐ Yes ☐ No
- I would like my child's emergency medication kept in the:

  ☐ School Office ☐ Classroom ☐ School Office and Classroom
- If the emergency medication is kept in the classroom, the medication should be transported by school personnel wherever my child travels to within the school: ☐ Yes ☐ No
- I would like to accompany my child on field trips: ☐ Yes ☐ No
- Students in the classroom should be encouraged to wash their hands upon arrival to school and after eating lunch: ☐ Yes ☐ No
- I will provide a shelf-stable allergen free snack that will be available in the classroom, if needed: ☐ Yes ☐ No

Please list other accommodations needed at school or other concerns we should be aware of:

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Parent Signature: ________________________________ Date: ____________________________