KUNA SCHOOL DISTRICT #3
1450 BOISE STREET KUNA, ID 83634. PHONE (208) 922-1000

Allergy Assessment Form

Date: _____ School: _____

Dear Parent/Guardian:

We are reviewing health records for students with allergies. Please help us update your child's health record by completing this form and returning it to the school.

In the event your child has an allergic reaction at school, he/she will be given first aid and you will be notified immediately. Emergency medical services will be called if necessary

Thank you for your help with this matter.

Sincerely,

_____
School Nurse

Allergy to: _____
(For children with multiple food allergies, use one form for each food.)

Student's Name: _____ Birth date: _____ Teacher/Grade: _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W) _____(C)_____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W) _____(C)_____

Physician Child Sees for Allergies: _____

Address: _____

Phone: _____

1. Identify the signs and symptoms related to an allergic reaction:

____Rash	____Hives/Welts	____Stomach ache or cramping
____Itching	____Sensation of warmth	____Diarrhea
____Dizzy/Faint	____Headache	____Lightheaded
____Nasal Congestion	____Runny Nose	____Wheezing
____Shortness of breath	____Sneezing	____Throat tightening
____Chest discomfort	____Coughing	____ Difficulty Swallowing
____Difficulty Breathing	____Nausea/Vomiting	____Other: _____
____Swelling of tongue, eyelids, face		

2. Rate the severity of the allergic reaction: ____Mild ____Moderate ____Severe

3. Is there a history of an anaphylactic reaction? ____Yes ____No

Describe:_____

4. Reaction caused by: ____ Ingestion _____ Contact _____ Inhalation

5. When was this allergy discovered? _____

6. When was your child last evaluated for the allergy? _____

7. Does your child have a history of asthma? ____Yes ____No If you answered yes, then please answer the following questions.
Does your child use bronchodilators (inhalers)? ____Yes ____No
Does your child wake up at night with asthma symptoms? ____Yes ____No
Does your child use medication at night or upon awakening in the morning? ____Yes ____No

8. Does exercise induce the allergy? ____Yes ____No

9. Does your child recognize his/her allergic reaction? ____Yes ____No

10. Does your child know what to do if he/she is having an allergic reaction? ____Yes ____No

11. Are there any other specific foods/items your child should avoid? _____

12. Is your child able to visually recognize the allergen in all its different forms (ex: peanut: peanut butter, peanuts etc.) or part of another food (ex. peanut butter cookie)? ____Yes____No

13. Is your child able to read labels for the offending allergen? _____Yes _____No

14. Your child knows to eat only food brought from your home. _____Yes _____No

15. Your child knows not to trade or take food from classmates and adults. _____Yes _____No

16. Your child understands how a safe food may become cross-contaminated with an allergen. _____Yes _____No

17. Will your child need to eat at an allergen free lunch table? _____ Yes _____ No

18. Will your child take medication regularly or on an "as needed" basis for this allergy? ____Yes* ____No

Medication Name	Route	Dosage	Time
1.			
2.			
3.			
4.			

*(Signed parental consent for medication must be on file at school and updated yearly.)

19. Does your child need epinephrine? ____Yes ____No

20. Will your child carry their emergency medication at school? * ____Yes ____No ____N/A

21. Does your child have a medical alert bracelet? ____Yes ____No

*If your child is carrying emergency medication, the school may require additional medication in the nurse's office.