Life-Threatening Allergy Assessment Form

Name_____ **Grade** _____ **Date of Birth**_____

Address_____

Father/Guardian Name_____

Home Phone_____ **Work** _____ **Cell**_____

Mother/Guardian Name _____

Home Phone _____ **Work**_____ **Cell**_____

1. Please list your child's life-threatening allergies:

_____ _____ _____

_____ _____ _____

_____ _____ _____

2. When was your child diagnosed with a life threatening allergy? _____

3. Who made the diagnosis ? _____

4. How was the allergy diagnosed?
   - ☐ Exposure incident
   - ☐ Skin test
   - ☐ Blood test
   - ☐ Food challenge

5. How often does your child follow up for their allergy(s)with a health care provider?_____

6. When was your child's last visit? _____

7. How often has your child had an exposure incident?
   - Total number_____
   - Number this year_____

8. What physical reaction did your child experience when there was an exposure incident?

_____

_____

9. How often has your child received medication/treatment for an exposure incident?
   - Benadryl _____
   - Epinephrine_____
   - Other_____

10. How often has your child had Emergency Room visits for an exposure incident?
    - Total number_____
    - Number this year_____

11. What does your child understand about life-threatening allergies and medication? _____

_____

12. Does your child carry epinephrine (EpiPen, Auvi-Q etc.) on their person outside the school setting? _____

13. Would your child be able to self-administer the EpiPen if necessary?_____

14. What do you do at home to keep the environment allergy-free (e.g., do others eat peanuts or other allergens in your home)? _____

_____

15. Describe your child's ability to advocate for himself (e.g. does he/she know not to share or trade food, state their allergy, wash their hands before and after eating, read food labels)? _____

_____

16. Does your child wear any medical alert identification? _____

17. With what non life-threatening allergies, if any, has your child been diagnosed?

_____ _____ _____

18. Does your child have asthma? _____

Completed by: _____Relationship to Student _____ Date: _____

Primary Care Physician: _____ Phone Number: _____

Allergist: _____ Phone Number: _____

Update:_____ Update:_____ Update:_____