Life-Threatening Allergy Assessment Form

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

School_____ **School Year** _____

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

_____

2. Diagnosed when? _____ By whom? _____

3. How was the allergy diagnosed (RAST testing, skin prick testing)?_____

4. Last known exposure: _____

5. Symptoms after exposure: _____

6. Name and phone number of primary care physician and/or allergist:

_____

7. How often does your child follow up with the above health care provider?_____

8. When was your child's last visit? _____ 9. Does your child have asthma? _____

10. Has your child ever required the use of epinephrine (Epi-Pen or Twin Jet)? _____

11. If so, how often has it been used _____ When was the last time it was used? _____

12. Does your child carry epinephrine (Epi-Pen or Twin- Jet) on their person outside the school setting? _____

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

14. Is your home an allergen-free environment (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. Comments: _____

_____

Completed by: _____ Relationship to Student _____ Date: _____

Update_____ Update_____ Update_____

5/08