



Wentzville School District Food Allergy Questionnaire

Student Name: _____ **Date of Birth:** _____ **Date:** _____

Physician's Name: _____ **Phone:** _____

Do you think your child's food allergy may be life-threatening? Yes No

Did your child's doctor tell you the food allergy may be life threatening? Yes No

HISTORY AND CURRENT STATUS-

Type of food allergy: _____

Has allergy testing been completed? Yes No If yes, date of testing: _____

Classification: Mild Moderate Severe

How many times has your child had a reaction? Never Once More than once

Date and Description of Episode(s): _____

Was the allergic reaction treated at a clinic or hospital? If yes, explain: _____

If your child has an egg or dairy allergy, does he/she eat baked goods containing egg or milk? Yes No

TRIGGERS AND SYMPTOMS-

What has to happen for your child to react to the food allergen(s)? Check all that apply:

Ingesting Foods Touching Foods Other, please explain _____

What are the signs and symptoms of your child's allergic reaction? How quickly do the symptoms appear after exposure? Be specific, include words your child would use to describe what he/she is feeling.

Does your child understand how to avoid foods that cause an allergic reaction? Yes No

RECOMMENDATIONS FOR SCHOOL-

Do you want your child to sit at the allergy aware table in the cafeteria? Yes No

Special food requirements: Yes No If yes, explain: _____

Please have physician complete attached Special Meals form

Special classroom accommodations: Yes No If yes, explain: _____

Classroom/School Parties, Birthday Treats, Snacks, & Food treats will be handled as follows:

Parent supplies all snacks and treats for child to be stored in classroom.

Parent provides "safe snack" list to be shared with classroom parents.

Field trips- All treatment supplies are taken along and care is provided:

By accompanying parent.

By school staff trained in student's emergency action plan.

Activities student can self-manage:

Will not trade food with others.

Will not eat anything with unknown ingredients or known allergen(s).

Will notify adult immediately if they ingest something they believe may contain allergen(s).

A Medication authorization form must be on file with your child's School Nurse to supply and store medication at school.

Parent's Signature: _____ **Date:** _____