BARRINGTON 220
COMMUNITY UNIT SCHOOL DISTRICT

ALLERGY ASSESSMENT FORM

Student Name:_____ Date of Birth:_____ Date:

Parent / Guardian:_____ Phone:

Health Care Provider (name) treating food allergy:_____ Phone:

Do **you think** your child's allergy may be **life-threatening?** ☐ No ☐ Yes
(If YES, please contact the school nurse as soon as possible)

Check any allergies that caused your child to have an allergic reaction:

A. ☐ Food (list type)_____
B. ☐ Insect stings (list type)_____
C. ☐ Animals (list type)_____
D. ☐ Other (list)_____

When and how did you first become aware of the allergy?_____
_____

How many times has your child had a reaction? ☐ Never ☐ Once ☐ More than once, explain:
_____
_____

When was your child's last allergic reaction?_____

Are the allergy reactions: ☐ staying the same ☐ getting worse ☐ getting better

What has to happen for your child to react to the problem allergy/allergies?
☐ Eating foods ☐ Touching foods/allergen ☐ Other, explain:_____

Please describe the signs and symptoms of the reaction. (Be specific, include things your child might say.)
_____

How quickly do the signs and symptoms appear after exposure to food(s) or allergens?
☐ Seconds ☐ Minutes ☐ Hours ☐ Days

Has your child ever needed treatment at a clinic or hospital for an allergic reaction? ☐ No ☐ Yes

Please describe:_____

Has your child every received or used an EpiPen or other injection treatment? ☐ No ☐ Yes
Please describe:_____

Does your child wear a Medic Alert bracelet? ☐ No ☐ Yes

Does your child understand how to avoid foods/ allergens that cause allergic reactions? ☐ No ☐ Yes

What treatment or medication has your doctor recommended for use in an allergic reaction?____
_____ Have you used the treatment? ☐ No ☐ Yes

Does your child know how to use the treatment? ☐ No ☐ Yes

If medication is to be available at school, the medication form and/or anaphylaxis action plan must be completed by both the licensed medical provider and the parent/guardian. Parent/guardian is responsible for bringing the medication/treatment supplies to school.

Reviewed by R.N.:_____ Date:_____