Food Allergy Questionnaire
School Year- 2019-2020
This form must be updated/received every school year

Student's Name:_______________________ Teacher:_______________________
Date of Birth:_________________________ Weight:________________________
Parent/Guardian Name:__________________________________ Phone#:_______________
Parent/Guardian Name:__________________________________ Phone#:_______________

Please list the specific food allergies and symptoms experienced:

Food	Symptoms Experienced
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

1. Is your child allergic to touching a food listed above? Yes or No. Name of Food:_______________________

2. Is your child allergic to smelling a food listed above? Yes or No. Name of Food:_______________________

3. Does your child see an allergist? Yes or No
   Name of allergist?___________________________ Phone #:____________________

4. Has your child's physician prescribed an Epi-Pen? Yes or No

5. How many times has your child required the use of an Epi-Pen? ___________

6. Has your child ever been treated in the emergency room or hospitalized due to a food allergy?
   Please explain:____
   ____

7. What medications have you given to your child to reverse his/her symptoms related to food allergies? Please list all:
   ____
   ____

8. Does your child refuse to accept food from another child? Yes or No

9. Does your child need to sit away from students that have peanuts or peanut butter for lunch? Yes or No

10. Are you willing to provide an allergen free "treat" in a container to freeze to be kept at school for classroom celebrations?
    Yes or No

Parent Signature:______________________________________ Date:____________________________