ST. LUKE SCHOOL
FOOD ALLERGY QUESTIONNAIRE

Student's Name_____ Grade_____ Teacher_____
Date of Birth_____ Weight_____
Parent/Guardian Name(s) _____ Phone _____

Foods that the student is allergic to and symptoms experienced:
Food_____ Symptoms Experienced _____
Food_____ Symptoms Experienced_____
Food_____ Symptoms Experienced _____
Food_____ Symptoms Experienced _____

1. Does your child experience allergic symptoms by **TOUCHING** a food listed above? Yes or No
   If YES, which food? _____
2. Does your child experience allergic symptoms to **SMELLING** a food listed above? Yes or No
   If YES, which food? _____
3. Does your child see an allergist? Yes or No
   Name of Allergist_____ Phone: _____
4. Does your child need an antihistamine? Yes or No
   If yes, has use been required? _____
5. Does your child need an Epi Pen? Yes or No
   If yes, how many times has use been required? _____
6. Has your child ever been treated in the Emergency Room or hospitalized due to a food allergy? If so please explain_____
   _____
7. Does your child know how to refuse to accept food from another child? Yes or No
8. Does your child need to sit away from students that have peanut products for lunch? Yes or No
9. What action would you like for us to take medical or non-medical in case of accidental ingestion of the above allergen(s)?
   _____
   _____
   _____

PARENT/GUARDIAN SIGNATURE _____ DATE_____