

PTC HEALTH SERVICES PROCEDURE

FOOD ALLERGY ASSESSMENT FORM

STUDENT NAME _____ BIRTH DATE _____

SPECIFIC LIFE-THREATENING ALLERGY: _____

Has your child had a serious reaction? Yes _____ No _____

If yes, when? _____ Describe _____

Has your child been tested by a physician for this allergy? _____

When is your child most affected by allergies?

Fall _____ Winter _____ Spring _____ Summer _____ No special season _____

How often does your child see the doctor because of allergies? _____

What medication do you use at home for allergy treatment? _____

How might your child's allergic condition affect camp performance or participation in activities?

Does your child need to eat lunch at a tree-nut free table? Yes _____ No _____

Is there anything else you would like to add? _____

Make food choices

Sit at the proper lunch table

Appropriate food choices at lunch, snacks, parties

Carry & administer Epi-Pen safely