

Ankeny Christian Academy Food Allergy Questionnaire

Child's Name _____ Child's Age/Grade _____

Father's Name _____ Emergency Phone _____

Mother's Name _____ Emergency Phone _____

1. Please list all foods that your child is allergic to: _____

2. How many times has your child had a reaction to each food? _____

3. Please explain in detail about your child's reaction to the ingestion of the food(s) you have listed. Include what age your child was at the time of the reaction, what symptoms your child had during the reaction and what medical care and medications were required to treat the reaction (please use the back side of this sheet if more space is needed.):

4. We will do everything possible to prevent your child from having a food allergy problem while they are in our care. In the unlikely event your child is exposed to the food they are allergic to and we are unable to reach you, what steps do you want the staff to implement for your child:

5. Has your child had a reaction to food manufactured/produced/packaged in a plant that also handles the food your child is allergic to? _____

6. Has your child had a reaction to the smell of the food? Yes _____ No _____

7. Has your child had a reaction from touching the food? Yes _____ No _____

8. If yes to questions 5, 6 or 7, please give specific details, using the back side of this sheet if needed.

9. Does your child have an Epi-Pen? Yes _____ No _____

If yes, you will need to provide an Epi-Pen that is kept in our building for your child.

10. Please list any medications that your child takes in the event of a food allergy reaction:

You will need to provide any medication to be kept in the building in original packaging for your child.

11. Please list your child's specific symptoms when an allergic reaction is occurring: _____

12. How does your child act when an allergic reaction is occurring: _____

13. Is your child under a doctor's care for their food allergy? Yes _____ No _____

Doctor's Name: _____

Address: _____ Phone Number: _____

If necessary, which hospital should your child be sent to? _____

14. Please list any additional information you feel is important: _____

Parent/Guardian Signature _____ Date _____