Food Allergy Evaluation/Provider Questionnaire

Please complete this form regarding your patient’s food allergy. This form will assist Regis University Student Disability Services to adequately assess the needs of each individual student and plan effectively. This form must be completed by a medical professional (i.e. RN, NP, PA and/or MD)

1. **What food(s) is the student/patient allergic to?**
   Check all that apply. Name the specific food causing the reaction.
   - [ ] Tree nuts specifically: ________________________________
   - [ ] Fish specifically: ________________________________
   - [ ] Shellfish specifically: ________________________________
   - [ ] Fruit specifically: ________________________________
   - [ ] Dairy specifically: ________________________________
   - [ ] Peanuts
   - [ ] Egg
   - [ ] Wheat
   - [ ] Soy
   - [ ] Other specifically: ________________________________

2. **Is this an airborne food allergy or other?**
   Check all that apply. The student/patient has a reaction when he/she:
   - [ ] Eats a food or another food containing the food allergen.
   - [ ] Touches a surface contaminated with oils from the food allergen.
   - [ ] Breathes odors from the food allergen while the food is being cooked or processed.
   - [ ] Other: ____________________________________________

3. **What are the symptoms of the student/patient’s food allergy?**
   Check all that apply. Reaction/intolerance includes:
   - [ ] Nausea and vomiting
   - [ ] Cramping and/or abdominal pain
   - [ ] Facial swelling, itching, welts or hives
   - [ ] Swelling of the lips, nose, tongue or throat.
   - [ ] Respiratory changes, difficulty breathing, wheezing, or continuous coughing.
   - [ ] Inability to speak or swallow.
   - [ ] Flushed face
   - [ ] Drooling
   - [ ] Complains that the throat feels tight, scratchy, or different in some way.
   - [ ] Other: ____________________________________________
4. **When is the onset of symptoms after ingestion?**
   Check all that apply.
   - [ ] Immediately
   - [ ] Within 15 minutes
   - [ ] Within one hour
   - [ ] Up to two hours
   - [ ] Other: ________________________________

5. **Please classify the severity of the student/patient’s food allergy?**
   - [ ] Mild
   - [ ] Moderate
   - [ ] Severe

6. **Is this food allergy life threatening?**
   - [ ] Yes
   - [ ] No

7. **Does the student/patient have an emergency and/or food allergy action plan?**
   - [ ] Yes, if so please attach copy
   - [ ] No

STUDENT/PATIENT’S NAME __________________________________________

YOUR NAME (PLEASE PRINT) ________________________________________

SIGNATURE & CREDENTIALS _________________________________________

ADDRESS _________________________________________________________

PHONE NUMBER ____________________    FAX _________________________