Food Allergy Evaluation/Provider Questionnaire

Please complete this form regarding your patient’s food allergy. This form will assist the Regis University Student Disability Services & University Testing to adequately assess the needs of each individual student and plan effectively. This form should 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.

<table>
<thead>
<tr>
<th>Food</th>
<th>Specifically:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tree Nuts</td>
<td></td>
</tr>
<tr>
<td>Fish</td>
<td></td>
</tr>
<tr>
<td>Shellfish</td>
<td></td>
</tr>
<tr>
<td>Fruit</td>
<td></td>
</tr>
<tr>
<td>Dairy</td>
<td></td>
</tr>
<tr>
<td>Peanuts</td>
<td></td>
</tr>
<tr>
<td>Egg</td>
<td></td>
</tr>
<tr>
<td>Wheat</td>
<td></td>
</tr>
<tr>
<td>Soy</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Specifically:</td>
</tr>
</tbody>
</table>

2. **Is this an airborne food allergy or other?**
   
   **Check all that apply.** The student/patient has a reaction when he/she eats:

   - 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 include(s):

   - 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 the answer is yes, please attach a copy to this form
   - [ ] No
     If the answer is no, please explain below
     
     ............................................................................................................................
     ............................................................................................................................
     ............................................................................................................................
     ............................................................................................................................

Student/Patient’s Name __________________________________________________________

Your Name (Please Print) ____________________________________ Date________________

Signature & Credentials ________________________________________________________

Address ______________________________________________________________________

Phone Number _________________________________ Fax____________________________