REGIS UNIVERSITY

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.

- ☐ 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:

- ☐ 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

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Student/Patient's Name ____

Your Name (Please Print) ______________________________ Date________________

Signature & Credentials ____

Address ____

Phone Number ______________________________ Fax______________________________