Life-Threatening Food Allergy
Parent Questionnaire

Student's Name:____ Grade: ____________

Food	Symptoms	Airborne	Contact	Ingestion Only
		Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No
		Yes No	Yes No	Yes No

Has your child had a reaction to one of these foods before? YES NO

If yes please describe reaction and treatment:____________________________________

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Does your child need a peanut or tree nut free classroom? YES NO

Does your child need to sit at the peanut/tree nut free table in the cafeteria? YES NO

Anything else we should know ____

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Parent Printed Name____

Parent Signature ____ Date __________