

## Regis University Student Disability Services

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## 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					
	☐ Dairy	specifically:				
	☐ Peanuts					
	□ Egg					
	□ Wheat					
	□ Soy	specifically.				
	☐ 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.					
	<ul> <li>□ Touches a surface contaminated with oils from the food allergen.</li> <li>□ Breathes odors from the food allergen while the food is being cooked or processed.</li> </ul>					
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	□ Other					
3.	What are the s	ymptoms of the stu	udent/patient's food allergy?			
	Check all that a	oply. Reaction/into	lerance includes:			
		☐ Nausea and vomiting				
		and/or abdominal p				
	Facial swelling, itching, welts or hives					
	_	the lips, nose, tong				
	•		breathing, wheezing, or continuous coughing.			
	•	speak or swallow.				
	☐ Flushed fa	ce				
	☐ Drooling		Landa de la companya			
		that the throat feel	Is tight, scratchy, or different in some way.			
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4.	When is the onset of symptoms after ingestion?						
	Check all	that apply.					
	☐ Imm	ediately					
		in 15 minutes					
		in one hour					
		o two hours					
	•	er:					
_							
5.	Please classify the severity of the student/patient's food allergy?  ☐ Mild						
	□ Jeve	ie					
6.	Is this food allergy life threatening?						
	☐ Yes						
	□ No						
<i>7.</i>	Does the student/patient have an emergency and/or food allergy action plan?						
	☐ Yes, if so please attach copy						
	□ No	•					
CTUD	ENIT/DATIEN	T'C NIANAE					
STUDENT/PATIENT'S NAME							
YOUR NAME (PLEASE PRINT)  SIGNATURE & CREDENTIALS							
ADDF							
PHONE NUMBER			Fax				