# HEALTH PACKET

Lower Elementary

Upper Elementary

Middle School

# PREPARTICIPATION PHYSICAL EVALUATION

## STUDENT HEALTH HISTORY

Date of Exam _____

Name _____ Date of birth _____

**Gender**_____ **Age**_____ **Grade**_____

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

**Explain "Yes" answers below. Circle questions you don't know the answers to.**

| GENERAL QUESTIONS | Yes | No |
|---|---|---|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. Do you wear glasses or contact lenses? | | |
| 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 47. Do you worry about your weight? | | |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 50. Have you ever had an eating disorder? | | |
| 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| **FEMALES ONLY** | | |
| 52. Have you ever had a menstrual period? | | |
| 53. How old were you when you had your first menstrual period? | | |
| 54. How many periods have you had in the last 12 months? | | |

**Explain "yes" answers here**

_____

_____

_____

_____

_____

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

***Parent/Guardian Signature_____Date_____



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*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

**NOTE:** The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

# PREPARTICIPATION PHYSICAL EVALUATION
# PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

## PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

| **EXAMINATION** | | |
|---|---|---|
| Height Weight ☐ Male ☐ Female | | |
| BP / ( / ) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic[c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____



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*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

# PREPARTICIPATION PHYSICAL EVALUATION
# CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

_____

_____

_____

_____

**EMERGENCY INFORMATION**

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

**HCP OFFICE STAMP**

**SCHOOL PHYSICIAN:**

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature:_____

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

**Completed Cardiac Assessment Professional Development Module**

Date_____ Signature_____



*New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71*

The Village School Est. 1977
Montessori Education

# Medication Form

Authorization for Prescription and Non-Prescription Medication to be given during school
(including afterschool programs & field trips)

NAME: _____DATE OF BIRTH_____

**ALL prescription and non-prescription medication to be administered at school, including afterschool programs and field trips, can only be given if this form is on file in our Health Office and signed by both the child's parent/guardian and physician.**

**Prescription Medication:**

| Drug Name | Dose | Frequency | Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Non-Prescription Medications:**

___Acetaminophen ___Ibuprofen ___ Antacids

___Motion Sickness Medication ___Hydrocortisone Cream ___Cough Drops

___Benadryl/Antihistamines ___Other Health-Related Products _____

_____ _____ _____

___ I authorize the school nurse or other school employee, trained by the nurse to administer the above medication to my child during school hours or other times when my child is participating in a school related activity, according to the frequency and/or directions indicated for my child. I understand that The Village School, school nurse or other school employees shall incur no liability as a result of any injury arising from the administration of medication; that I will indemnify and hold harmless the school, the school nurse and other school employees against any claims arising from the administration to my child.

____ NO prescription or non-prescription medications are to be administered to my child.

Parent/Guardian Signature_____Date_____

Physician's Signature: _____Date: _____

Physician's Stamp/Address _____

All medications MUST be in their original containers, marked with the child's name and brought to the Health Office by a parent/guardian for dispensing in school at the start of the school year; and for field trips at least one week prior to the field trips.

# Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**

PACNJ Pediatric/Adult Asthma Coalition

Sponsored by AMERICAN LUNG ASSOCIATION. IN NEW JERSEY

NJ Health New Jersey Department of Health

**(Please Print)**

| Name | Date of Birth | Effective Date |
|---|---|---|
| Doctor<br>Phone | Parent/Guardian (if applicable)<br>Phone | Emergency Contact<br>Phone |

## HEALTHY (Green Zone)

**You have *all* of these:**

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

**Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.**

| MEDICINE | HOW MUCH to take and HOW OFTEN to take it |
|---|---|
| ☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230 | 2 puffs twice a day |
| ☐ Aerospan™ | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Alvesco® ☐ 80, ☐ 160 | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Dulera® ☐ 100, ☐ 200 | 2 puffs twice a day |
| ☐ Flovent® ☐ 44, ☐ 110, ☐ 220 | 2 puffs twice a day |
| ☐ Qvar® ☐ 40, ☐ 80 | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Symbicort® ☐ 80, ☐ 160 | ☐ 1, ☐ 2 puffs twice a day |
| ☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500 | 1 inhalation twice a day |
| ☐ Asmanex® Twisthaler® ☐ 110, ☐ 220 | ☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day |
| ☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250 | 1 inhalation twice a day |
| ☐ Pulmicort Flexhaler® ☐ 90, ☐ 180 | ☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day |
| ☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0 | 1 unit nebulized ☐ once or ☐ twice a day |
| ☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg | 1 tablet daily |
| ☐ Other | |
| ☐ None | |

***Remember to rinse your mouth after taking inhaled medicine.***

**If exercise triggers your asthma, take_____ ____ puff(s) ____minutes before exercise.**

## CAUTION (Yellow Zone)

**You have *any* of these:**

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

| MEDICINE | HOW MUCH to take and HOW OFTEN to take it |
|---|---|
| ☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®) | 2 puffs every 4 hours as needed |
| ☐ Xopenex® | 2 puffs every 4 hours as needed |
| ☐ Albuterol ☐ 1.25, ☐ 2.5 mg | 1 unit nebulized every 4 hours as needed |
| ☐ Duoneb® | 1 unit nebulized every 4 hours as needed |
| ☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg | 1 unit nebulized every 4 hours as needed |
| ☐ Combivent Respimat® | 1 inhalation 4 times a day |
| ☐ Increase the dose of, or add: | |
| ☐ Other | |

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

## EMERGENCY (Red Zone)

**Your asthma is getting worse fast:**

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

**Take these medicines NOW and CALL 911.**

***Asthma can be a life-threatening illness. Do not wait!***

| MEDICINE | HOW MUCH to take and HOW OFTEN to take it |
|---|---|
| ☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®) | 4 puffs every 20 minutes |
| ☐ Xopenex® | 4 puffs every 20 minutes |
| ☐ Albuterol ☐ 1.25, ☐ 2.5 mg | 1 unit nebulized every 20 minutes |
| ☐ Duoneb® | 1 unit nebulized every 20 minutes |
| ☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg | 1 unit nebulized every 20 minutes |
| ☐ Combivent Respimat® | 1 inhalation 4 times a day |
| ☐ Other | |

## Triggers

**Check all items that trigger patient's asthma:**

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - ○ Dust Mites, dust, stuffed animals, carpet
  - ○ Pollen - trees, grass, weeds
  - ○ Mold
  - ○ Pets - animal dander
  - ○ Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - ○ Cigarette smoke & second hand smoke
  - ○ Perfumes, cleaning products, scented products
  - ○ Smoke from burning wood, inside or outside
- ❑ Weather
  - ○ Sudden temperature change
  - ○ Extreme weather - hot and cold
  - ○ Ozone alert days
- ❑ Foods:
  - ○ _____
  - ○ _____
  - ○ _____
- ❑ Other:
  - ○ _____
  - ○ _____
  - ○ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.



**REVISED MAY 2017**



**Permission to Self-administer Medication:**

- ☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- ☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_____ DATE_____

Physician's Orders

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

**Make a copy for parent and for physician file, send original to school nurse or child care provider.**

# Asthma Treatment Plan – Student
## Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

**1. Parents/Guardians:** *Before taking this form to your Health Care Provider,* complete the top left section with:
- Child's name
- Child's date of birth
- Child's doctor's name & phone number
- An Emergency Contact person's name & phone number
- Parent/Guardian's name & phone number

**2. Your Health Care Provider will** complete the following areas:
- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER" and:**
  - ❖ **Write in asthma medications not listed on the form**
  - ❖ **Write in additional medications that will control your asthma**
  - ❖ **Write in generic medications in place of the name brand on the form**
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

**3. Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

**4. Parents/Guardians:** *After completing the form with your Health Care Provider:*
- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

**PARENT AUTHORIZATION**

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

_____ _____ _____

Parent/Guardian Signature | Phone | Date

**FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.**

***RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY***

☐ I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

_____ _____ _____

Parent/Guardian Signature | Phone | Date

PACNJ Pediatric/Adult Asthma Coalition



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The Village School Est. 1977
Montessori Education

# Physician's Orders for Allergy Emergency Treatment
# Individualized Emergency Care Plan

Student's Name: _____
Birth Date: _____Class:_____

**Physician's Orders: (To be filled out by Physician)**

The above student is allergic to _____
Previous episode of anaphylaxis ____ Yes _____ No
If yes, please explain_____
History of asthma ____ Yes _____No
If yes, supply **Asthma Action Plan**

## MEDICATIONS

**Antihistamine: Name _____ Dose: _____**

Give antihistamine for the following symptoms:
_____
_____
_____

**Epinephrine: ___ EpiPen ____ EpiPen Jr. _____ Other _____**

Give Epinephrine for the following symptoms:
_____
_____
_____

**Choose one administration order:**
___ Give Anthihistamine first, observe, for further symptoms and give Epinephrine PRN
___ Give Antihistamine only
___ Give Epinephrine only

___ This student has been trained and is capable of self-administration of the following medication(s)
___ Epinephrine – single dose unit

___ This student is not capable of self-administration of the medications named above.

Please Note: Under NJ state law, in the absence of a school nurse, a trained delegate will give epinephrine only, any antihistamine order will be disregarded.

Physician's Name: _____Date_____

Physician's Signature:_____

Physician's Address: _____

Physician's Phone: _____Fax _____

## Authoriztion: To Be Filled Out By Parent:

I authorize the school nurse/principal/administrator to contact my physician on any questions related to the care of my child's care. I also authorize the school nurse or other unlicensed assistive individuals educated by the nurse to administer the above medication to my child during regular school hours and at other times when my child is participating in a school related event. I authorize my child to engage in self-administration if appropriate. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the administration of this medication; and that I will indemnify and hold harmless The Board of Education/School District, Bergen County Department of Health Services and their employees, school, school nurse and other school employees against any claims arising from the administration to my child.

Child's Name: _____

Parent's Name: _____

Signature: _____Date_____
**(Parent/Guardian)**

The Village School Est. 1977
Montessori Education

# Snack Requirements for Food Allergy Students

Please return this form to The Village School Health Office if your child has a documented food allergy. This form will be in effect for the duration of the school year.

Name_____

Class:_____

☐ I have provided The Village School with information regarding my child's food allergies.
I want my child_____ to be served **ONLY** the snack I have provided.

☐ I have provided The Village School with information regarding my child's food allergies.
My child_____**MAY** eat the community snack if the snack does not contain and/or the packaging does not indicate the allergen specified on my child's medical forms.

*All decisions regarding product content will be based on product labeling. Homemade snacks will not be served to children with food allergies as the school cannot guarantee their preparation.

Parent/GuardianSignature_____

Date_____

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thevillageschool.net