FRIENDSHIP SCHOOL
San Diego County Office of Education, 525 Third Street, Imperial Beach CA 91932
(858) 298-2213 FAX (619) 423-6007

FOOD ALLERGY/FOOD INTOLERANCE INFORMATION AND TREATMENT FORM

Food allergy or food intolerance has been noted to be a concern for your child. Please provide additional information regarding your child's reaction(s) to this food so that the school staff can follow the safest measures should an allergic reaction occur at the school.

Student:_____ Birth date: _____ Age: _____

Physician:_____ Clinic:_____

Food(s) allergic to:_____

Food intolerance(s):_____

My child's reaction to this/these foods include (check all that apply):

- ☐ Nausea, stomach upset, indigestion
- ☐ Abdominal discomfort, cramping, diarrhea
- ☐ Facial swelling, itching, welts or hives, generalized body flush
- ☐ Swelling of lips, nose tongue or throat, hoarseness, breathing and/or swallowing difficulty
- ☐ Other_____

The symptoms above occur (check all that apply):

- ☐ Almost immediately
- ☐ Within a few minutes
- ☐ Within 30 minutes to 2 hours
- ☐ Other_____

My child has been seen by a doctor for his/her allergy: ☐ yes ☐ no

Treatment my child received for his/her last allergic reaction: _____
_____
_____

If my child comes in contact with the food he/she is allergic to while at school, the following treatment should be given (Check all that apply):

- ☐ Call parent/guardian to send home if experiences abdominal cramping/diarrhea
- ☐ Give over-the-counter medication (not prescription) as follows*:
  - Name of Medication:_____
  - Amount/dosage:_____
- ☐ Child must have Epi pen or ANA kit*
  - ○ Immediately
  - ○ If symptoms occur. Describe symptoms:_____

_____

Note: If Epi pen or ANA kit is administered, 911 will be called.

Medication must be sent to school with a completed Medication Authorization Form. All medications to be given require a doctor's signature.

Parent/guardian signature: _____ Date:_____

Physician Signature: _____ Date:_____