Nooksack Valley School District

Food Modification Prescription Form

*To be completed by a RECOGNIZED MEDICAL AUTHORITY i.e., licensed physician, physician assistant or nurse practitioner

Student Name	Date of Birth	Today's Date
Parent/Guardian	**Phone/Cell**	**Work Phone**
Medical Professional completing this form and **Title**		**Phone**

Describe the student's condition:

* If this condition **is a life-threatening food allergy** an **EMERGENCY CARE PLAN /ANAPHYLATIC REACTION** form must also be on file with the NVSD's Health Office.

Is this a Food Allergy ? ☐ No ☐ Yes

Is this a Food Intolerance ? ☐ No ☐ Yes

What Triggers this reaction?
☐ Ingestion ☐ Contact ☐ Inhalation

Check the Foods that cause the reaction and should be omitted:

☐ Peanuts
☐ Tree nuts (walnuts, almonds, pecans, etc.)
☐ Soy products
☐ Fish
☐ Shellfish
☐ Wheat
☐ Citrus
☐ Other(be specific): ________________
☐ ________________
☐ ________________

☐ Eggs
☐ Eggs, listed as ingredient in baked product

DAIRY (Please check all the following that apply)
☐ Milk, Liquid
☐ Yogurt
☐ Cheese
☐ Milk, listed as an ingredient in baked product
☐ Ice Cream
☐ Other: ______________

Comments:

Please check the symptoms that happen when a reaction occurs:

☐ **GI Upset** ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea
☐ **Skin Reactions** ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling
☐ **Mouth** ☐ Itching ☐ Swelling
☐ **Throat** ☐ Itching ☐ Tightness ☐ Hoarseness ☐ Cough
☐ **Lungs** ☐ Shortness of Breath ☐ Wheezing

Others or comments: ____

____

Treatment

What treatment or medication do you recommended if a reaction occurs?

____

____

____

Parent/ Guardian Section

When was the last reaction? ____

Are the food allergy reactions: ☐ staying the same ☐ getting worse ☐ getting better

Does your child know how to avoid foods that cause them reactions? ☐No ☐ Yes

Will your student mostly be eating: ☐ School Breakfast ☐ School Lunch ☐ Meals from home

PHYSICIAN'S SIGNATURES

Licensed Health Care Providers Signature______________________	____________ Date
Licensed Health Care Providers Printed Name______________________	

NV Internal Office Use Only	
School Nurse Signature:	Date
Copies of this form were sent to: ☐ NV Food Services Office ☐ ____________________ ☐ School's Head Cook ☒ ____________________	