TRIAD LOCAL SCHOOLS
FOOD ALLERGY ALERT

PARENT: THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WITH A MEDICALLY DOCUMENTED FOOD ALLERGY.

Name of Student: _____ Date of Birth: _____ Grade: _____

Address: _____
Street Address City State Zip

A. I am alerting the school that the student named above has a severe food allergy. This child is allergic to the following foods:

☐ Egg ☐ Peanut ☐ Soy
☐ Fish ☐ Seeds: Sesame, sunflower, poppy, etc ☐ Wheat
☐ Milk ☐ Shellfish ☐ Other (Specify): _____
☐ Tree Nuts, which include but are not limited to: walnut, almond, hazelnut, coconut, cashew, pistachio, and Brazil nuts.

B. Allergy symptoms associated with the list above. Symptoms usually appear within _____ minutes.

☐ • Skin – Hives, itchy rash, swelling of the face or extremities
☐ • Abdomen – Nausea, abdominal cramps, vomiting, diarrhea
☐ • Throat – Hacking cough, tightening of throat, hoarseness
☐ • Mouth – Itching, tingling, or swelling of lips, tongue, mouth
☐ • Lung – Shortness of breath, repetitive cough, wheezing
☐ • Heart – Thready pulse, low blood pressure, fainting, pale, blueness
☐ • Mental – Sudden quietness or decreased responsiveness
☐ • Other: _____

C. Emergency action to be taken if allergen is ingested:

☐ Administer prescribed medication as indicated below from designated school personnel.
☐ Allow student to self-administer the prescribed medication in which should be in his/her possession.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

D. I release and agree to hold the Triad Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent _____ Date: _____
Parent, guardian or other person having care or charge of the student:

Parent DAYTIME Telephone: _____ Work Telephone: _____

Other Emergency Contact Name: _____ Relationship: _____

Emergency Contact's Telephone: _____ Other: _____

LICENSED PRESCRIBER: TRIAD SCHOOL DISTRICT REQUIRES THAT ALL OF THE FOLLOWING INFORMATION BE PROVIDED BEFORE FOOD SUBSTITUTIONS CAN BE OFFERED, OR SCHOOL PERSONNEL MAY ADMISTER MEDICATION OR TREATMENT TO THE ABOVE NAMED STUDENT. A COPY OF THIS COMPLETED FORM WILL BE KEPT ON FILE BY THE CAFETERIA SUPERVISOR.

Licensed Prescriber's statement: I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following emergency medication to the above named student

Student has been trained on the proper use of epi-pen. ____ Yes ____ No Student is capable of possessing and using epi-pen. ____ Yes ____ No

The medication should be used in the following circumstances: _____

Report the following severe adverse reactions to my office immediately: _____

Procedure to follow in the event that medication does not produce the expected relief of student's allergic reaction: _____

Prescriber's Signature _____ Office Telephone: _____

Printed/Typed Name _____ Date: _____

PARENT/GUARDIAN MUST ACKNOWLEDGE ONE OF THE FOLLOWING (PLEASE INITIAL):

The principal or school nurse has been provided with a back-up dose of the student's medication: _____ Yes _____ No

PRINCIPAL OR NURSE MUST ACKNOWLEDGE ONE OF THE FOLLOWING (PLEASE INITIAL):

I have received a back-up dose of the student's medication. _____ Yes _____ No

Copies must be provided to building principal, the school nurse and the cafeteria supervisor.

SPECIAL DIET FORM

This center/facility participates in in the Child and Adult Care Food Program and any meals, snacks, or milk claimed for reimbursement must meet program requirements. Food accommodations must be made when the food accommodation is due to a disability (a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment). Reasonable food accommodations may be made for children/participants without disabilities who may have special medical or dietary needs. Food accommodations are to be supported by a statement signed by a recognized State medical authority which is defined as a State licensed health care professional who is authorized to write medical prescriptions under State law.

To be completed by parent, guardian or authorized representative		
Child's/Participant's Name:		Birth Date:
Parent/Guardian/Authorized Representative Name:		
Email Address:		
Home Phone:	Work Phone:	Cell Phone:
Address:		
City:	State:	Zip:

To be completed by recognized State medical authority

Check and complete appropriate information. For the safety of the child, please be as specific as possible.

☐ **Yes, this child/participant has a disability that requires food accommodation?**

Describe disability:

What major life activity is affected?

How does the disability restrict the diet?

☐ **Child/Participant has no disability but requires a special diet**

Describe the medical or other special dietary need that restricts diet:

List food/type of food to be omitted.

List food/type of food to be substituted for omitted food(s). Please be specific regarding any needed food texture changes or detailed menu to be followed.

Signature of Recognized State Medical Authority:	**Date:**
Printed Name:	Phone:

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