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 their 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:_____