

Food Allergy/Intolerance Plan

Please complete this form for your child's food allergy/intolerance so staff can plan effectively for care at school.

Student name: _____

Grade: _____

School: _____

School year: _____

Food Allergen/Intolerance: (Check all applicable)

- Fruit/Vegetable Specify: _____
 Dairy Products Specify: _____
 Gluten Specify: _____
 Other Foods Specify: _____

The food reaction happens when my child is exposed to:

- Fresh foods
 Processed foods containing the food ingredient
 Cooked foods containing the food ingredient.
 Other - Describe: _____

My child can touch the food without a reaction.

YES

NO

My child can have limited amounts of listed foods at school.

YES

NO

My child can self-monitor the foods they eat.

YES

NO

Symptoms of child's food allergy/intolerance include:

- Nausea Vomiting
 Diarrhea Cramping and/or abdominal pain.
 Behavior changes – moody, irritable
 Other - Describe: _____

Onset of symptoms after ingestion:

- Immediately Within one hour
 Within 15 minutes Up to two hours

Food allergy/intolerance plan: (Check all applicable)

- Call me if my child exhibits any symptoms listed above after eating the food allergen.
- Observe my child for 30 minutes in the office.
- Give medication to my child. Observe my child for an additional 20 minutes. Call if symptoms don't resolve.

Medication Orders

Medicine	Dosage	Time/Frequency

I give permission for school personnel to administer the above listed medications as ordered to my child for the duration of the current school year. I give permission to share this information with staff on a need to know basis.

Signature(s) required for medication to be given at school.

Parent/Guardian Signature: _____ Phone#: _____ Date _____

Physician/Provider Signature: _____

Physician/Provider Phone#: _____ Date _____

Effective Date: From _____ To _____