Keller Independent School District
Health Services Department/Child Nutrition Department

Parent Statement of Food Allergy Information For Care of Students with Food Allergies At-Risk For Anaphylaxis

Pursuant to HB 742, school districts are required to request that a parent of an enrolling student disclose whether the student has a food allergy or a severe food allergy.

This form allows you to disclose whether your child has a food allergy or severe food allergy that you believe should be disclosed to the District in order to enable the District to take necessary precautions for your child's safety.

A severe food allergy is a dangerous or life-threatening reaction of the human body to a food-borne allergen induced by inhalation, ingestion or skin contact that requires immediate medical attention.

Please list any foods to which your child is allergic or severely allergic, as well as the nature of your child's reaction to the food.

Food	Allergic Reaction

The District will maintain the confidentiality of the information provided above and may disclose the information to teachers, school counselors, school nurses, and other appropriate school personnel only within the limitations of the Family Education Rights and Privacy Act and District Policy.

Student: _____ Date of Birth: _____

Grade: _____ Campus: _____ Date: _____

Parent/Guardian: _____

Work Phone: _____ Cell Phone:_____ Home Phone:_____

Parent/Guardian Signature: _____

Consistent with guidelines from the Texas Department of Agriculture, in order for the District to consider food substitutions for a student's food allergies, a physician-signed medical statement listing the child's disability, an explanation of why the disability restricts the child's diet, the major life activity affected by the disability, and food(s) that must be omitted or substituted must be provided.

TO BE COMPLETED BY PHYSICIAN:

Does the child's food allergy constitute a disability? ☐ Yes ☐ No

If yes, how does the disability restrict the student's diet? _____

_____

What major life activity is affected by the disability? _____

Foods To Avoid	Foods to be substituted (COMPLETED BY PHYSICIAN ONLY)

Physician Signature:_____ **Date**:_____

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To be completed by school personnel:

Date form received by the school nurse: _____

Date form provided to: Child Nutrition Dept.:_____ Transportation:_____

(if appropriate)

Revised 10/16