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: ___________________________

☐ YES ☐ NO

☐ YES ☐ NO

☐ 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)

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

Medication Orders

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dosage</th>
<th>Time/Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ___________________________ NPI #: __________________

Physician/Provider Phone#: ___________________________ Date: ________________

Effective Date: From ________________ To ________________

Computer/Shared/Middle/Private/Nurses/Action Plans/Food Allergy/Intolerance Plan Plan
Revised 5-10, Reviewed 5-14, Revised 5-16, Revised 12-16