

FOOD ALLERGY INFORMATION

Our school records show that your child has a food allergy. In order for school personnel to provide a safe environment for your child, we need additional information from you and your child's doctor.

Parent complete the following:

What is the date of your child's last allergic reaction to food? _____

Please circle the food your child had an allergic reaction to:

- | | |
|-----------------------------|----------------|
| a. peanuts/peanut products | f. wheat |
| b. tree nuts _____(type) | g. fish |
| c. eggs | h. shellfish |
| d. cow's milk/milk products | i. other _____ |
| e. soy products | |

The reaction occurred after this contact with allergen:

- a. ingesting
- b. touching
- c. inhaling

Circle the reaction your child has had to a food allergen:

- | | |
|---|---|
| a. itching or swelling of lips, tongue, or mouth | f. difficulty breathing, shortness of breath, wheezing, repetitive coughing |
| b. hives, itchy red skin, rash | g. difficulty swallowing or choking |
| c. swelling of face or extremities | h. nausea, vomiting, abdominal cramps or diarrhea |
| d. nasal congestion, runny nose, or sneezing | i. dizziness or fainting, shock, unconsciousness |
| e. throat itching or tightness, hacking cough, hoarseness | |

How long after eating did your child develop symptoms?

- a. immediately
- b. within 15-20 minutes
- c. within an hour
- d. longer than an hour _____

Does your child know how to avoid these foods and their byproducts? yes _____ no _____

Will your child be eating school-prepared lunches? yes _____ no _____

Will your child be eating lunches and snacks prepared only at home? yes _____ no _____

Has your child ever seen an allergist about food allergies? yes _____ no _____

Do school personnel have permission to communicate with your child's physician/allergist? yes _____ no _____

Physician Name _____

Allergist name _____

Address _____

Address _____

Phone _____

Phone _____

Parent Signature

Date

Physician complete the following:

Please note dates of any reactions to allergen(s): _____

The reaction occurred after this contact with allergen:

- a. ingesting
- b. touching
- c. inhaling

Please note type of reaction: _____

Have reactions resolved spontaneously or required medication (if so, what medication)? _____

Do you consider this allergy to be life threatening? Yes _____ No _____

Please provide documentation/explanation/testing results to the school regarding the severity of this allergy:

Does this child require medication for food allergy symptoms? Yes _____ No _____

If so, please complete the Food Allergy Action Plan attached.

Please circle accommodations the school needs to implement to help keep this child safe at school:

Training of staff in management of food allergies

Safest foods are those prepared at home. School may encourage family/child to eat food from home as much as possible.

School nurse/nutrition services director (or designee) should read all labels for presence of allergen in foods served to child at lunch

For grades K-5:

- signage that classroom is allergen-free
- training of classroom teacher to maintain allergen-free classroom
- communication with classmates' parents that classroom foods is allergen-free
- student will sit at allergen-free table for lunch
- handwashing by classmates after eating

Other _____

Other _____

Physician's signature

Date