Form 316-05

A picture containing text, lamp

Description automatically generated

|  |  |
| --- | --- |
| School |  |
| Teacher |  |
| Grade |  |

**FOOD ALLERGY**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student’s Name: | | | |  | | | | Birth Date: | |  |
| Parent 1 Name: | | |  | | | | | Relationship: | |  |
| Cell # |  | | | | | Work # |  | Home # |  | |
| Parent 2 Name: | | |  | | | | | Relationship: | |  |
| Cell # |  | | | | | Work # |  | Home # |  | |
| Emergency Contact 1: | | | | |  | | | Relationship: | |  |
| Cell # |  | | | | | Work # |  | Home # |  | |
| Emergency Contact 2: | | | | |  | | | Relationship: | |  |
| Cell # |  | | | | | Work # |  | Home # |  | |
| Doctor’s Name: | |  | | | | | | Phone # |  | |

Please tick (✓) all that apply:

**Previous Reactions**

|  |  |  |
| --- | --- | --- |
|  | Itchy eyes/runny, stuffy nose | |
|  | Flushes face/ hives on face/ lips or tongue swells | |
|  | Tightness in throat/ wheezing or difficulty breathing | |
|  | Vomiting/ diarrhea | |
|  | Other (please specify) |  |

**Timing Of Reactions**

|  |  |  |
| --- | --- | --- |
|  | Immediately | |
|  | Mild symptoms for 1-2 hours, then breathing difficulties | |
|  | Other Describe: |  |

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**Previous Treatment**

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please list the foods to which your child is allergic: |  | Which of the following medications have you provided? | | |
|  |  |  | Oral Antihistamine | |
|  |  |  | Type: |  |
|  |  |  | Dose: |  |
|  |  |  | Anakit | |
|  |  |  | Epipen | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does your child know which foods to avoid? |  | | | |
| What emergency care do you expect your child to receive at school? | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
| Does your child wear a Medic Alert bracelet? |  | | |  |
|  |  | | | |
| **PLEASE GET THE APPROPRIATE FORM FROM THE SCHOOL** | | | | |
|  | |  |  | |
| (Parent/Legal Guardian Signature) | |  | (Date) | |

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