Food Allergy/Intolerance Prescription

Sunman-Dearborn Community Schools Food Service
School Year _____

Dear Parent/Guardian:

You indicated to the school that your child has a significant food allergy or intolerance that could require *emergency treatment* while in school. In order to insure the best possible treatment plan, the Food Service Department must have a **written prescription from your doctor** (see below) to help avoid the food/s that produce an allergic reaction or intolerance in your child. Please return this information to the School Nurse as soon as possible.

Student's Name _____ DOB: _____
School: _____ Grade: _____ Room: _____

Food (list below-check each that apply)

1.	☐ Allergy ☐ Intolerance	3.	☐ Allergy ☐ Intolerance
2.	☐ Allergy ☐ Intolerance	4.	☐ Allergy ☐ Intolerance

Other: _____

Symptoms demonstrated by the student:

1. _____
2. _____
3. _____

I authorize that the above named child is allergic/intolerance to the food/s listed, may *require emergency treatment* and that the food/s should be avoided. Please check **all** that apply below:

☐ **suspected allergy** ☐ **documented allergic reaction** ☐ **required hospitalization**

☐ **Epi-Pen ordered** ☐ **other medication:** _____

When offending food is served: ☐ **child requires separate seating in the cafeteria**
☐ **child requires seating other than in the cafeteria**

→ Signature of Physician: _____
(Please print Physician's Name): _____
Telephone Number: _____ Date: _____

I read, reviewed and understand the food allergy/intolerance information formulated by my child's physician. I agree that it may be placed on file as part of my child's school health record and the necessary information is shared with S-DCS registered dietitians, my child's teacher and staff. S-DCS Food Service is permitted to contact my child's physician to obtain further explanation of the above information. This authorization is in force for the _____ school year unless I submit new information in writing to the school.

Signature of Parent/Guardian: _____ Date: _____
Daytime Telephone: _____ E-mail address: _____

Copy to Food Service ☐ Date: _____ Copy to Teacher ☐ Date: _____
Original in Student Health Record ☐ Date: _____
Signature of School Nurse: _____

Sunman-Dearborn Community Schools
Bright Elementary
Phone 812-637-4600
Fax 812-637-4606

INDIVIDUALIZED HEALTH CARE PLAN – FOOD ALLERGY

(FOR CLASSROOM/CAFETERIA)

NAME OF STUDENT:_____ DATE_____

ALLERGIC TO: _____

Allergic reaction occurs if: (*Circle all that apply):*

- *Ingested*
- *Touched*
- *Inhaled*

NEEDS MEDICATION: _____ EpiPen (**MD orders are *required***)
(Check all that apply) _____ Benadryl (What dose?) _____
_____ Other _____

PLAN FOR EATING WITH/APART FROM OTHERS:

_____ May eat with any students in the cafeteria
_____ Must eat at a peanut free table

CLASS PARTIES - Handle as follows (*Please check one)*

_____ Student may eat the treat(s)
_____ Student may take the treat(s) home
_____ Replace treat with parent supplied alternative
_____ Other – please explain & talk with teacher & nurse:

_____
_____

FIELD TRIPS: The emergency medications for your child will need to go on field trips. If you or a family member is to accompany the child, let the teacher know. Tell the teacher/nurse if you will bring the medication with you. If no family member will attend the trip, please call the nurse ahead of time so that the nurse can arrange for the medication to be sent on the field trip.

PARENT SIGNATURE: _____**DATE** _____