Form 316-05



|  |  |
| --- | --- |
| 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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