Cowichan Valley School District

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 (comment please)

Form 3525-07

Previous Treatment

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)

Form 3525-07