The Children's Schoolhouse Food Allergy/Restriction Form

Student's Name: _____ **D.O.B**.:_____

Parents Name: _____ Asthmatic Yes* ☐ No ☐

(*Higher risk for severe reaction)

Food Allergy to (and must be avoided due to life threatening reaction):

_____ _____

_____ _____

***Allergy Test Date**:_____

(*Must be within one year of first day of current school year)

Symptoms:		**Give Checked Medication:** (To be determined by physician authorizing treatment)
◊	If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
◊ Mouth	Itching, tingling, or swelling of lips tongue, mouth	☐ Epinephrine ☐ Antihistamine
◊ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
◊ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
◊ Throat	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
◊ Lung	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
◊ Heart	Fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
◊ Other	_____	☐ Epinephrine ☐ Antihistamine

DOSAGE

Epinephrine: give _____

medication/dose/route

Antihistamine: give _____

medication/dose/route

Notes from Physician (*Please Print): _____

_____

Physician Name: _____

Physician Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Parent's Emergency Contact Number: _____

Form must be completed, signed, & dated by physician at the start of each of your child's school years at The Children's Schoolhouse