Photo

FOOD ALLERGY ACTION PLAN

Student's Name: _____ Birthdate: _____

Allergic To: _____

Asthmatic ☐ Yes (Higher risk for severe reaction) ☐ No

► STEP 1: TREATMENT ◄

Symptoms:		**Give Checked Medication:**
•	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
• Stomach	nausea, cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
• Throat †	tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
• Lung †	shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
• Heart †	weak pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
• Other †	_____	☐ Epinephrine ☐ Antihistamine
•	If reaction is progressing (several of the above areas affected), give	☐ Epinephrine ☐ Antihistamine

† = **Potentially life- threatening**

Medication: specify dose and procedure required for the above treatment

Epinephrine: _____
medication/dose/procedure

Antihistamine: _____
medication/dose/procedure

Other: _____
medication/dose/procedure

► STEP 2: EMERGENCY CALLS ◄

	Name/Relationship	Phone Number(s)	
a.	_____	1.) _____	2.) _____
b.	_____	1.) _____	2.) _____
c.	_____	1.) _____	2.) _____

Preferred Hospital: _____ **Doctor's Name**: _____

_____ _____

Parent's Signature **Date**

► STEP 3: FOOD ACCOMMODATIONS ◄

This school/facility participates in a federally-funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable food accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable food accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement is required.

Does student need special food accommodations? _____.

If you are requesting a meal accommodation or substitution, **please ask your physician to complete and sign the form on the following page.**

School-Based Child Nutrition Programs

PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

Student's Name: _____ Birthdate: _____

PHYSICIAN STATEMENT:

1. Does child have a disability according to 7 CFR Part 15d that requires food accommodation? (Does he/she have a "physical or mental impairment which substantially limits one or more major life activities"?)

   ☐ No If no, go to item 2 below.

   ☐ Yes If yes, provide the following information and complete item 3, 4, and 5 below.

   a. What is the disability? _____

   b. What major life activity is affected? _____

   c. How does the disability restrict the diet? _____

2. Child has no disability but requires a special diet. Identify medical problem which restricts the child's diet and complete items 3, 4, and 5 below.

3. List food/type of food to be omitted. For the safety of the child, please be as specific as possible.

4. List food/type of food to be substituted. For the safety of the child, please be as specific as possible.

5. _____ _____
   Physician's Signature **Date**

FOR OFFICE USE ONLY:

☐ Form received on _____.

☐ Form complete and accommodations will begin on_____.

☐ Form Complete Accommodation will not be made due to:

   ☐ Child does not have a disability

   ☐ Request not reasonable

☐ Form incomplete. Parent contacted on _____.