Health Services Request Form – C
Food Intolerance/Allergy Action Plan

Place Child's Picture Here

PART I: To be completed by Parent/Guardian and/or Local Agency

Child's Name: ______________________________ Birth Date: __________________

Attendance Center (school, child care, etc.): ____________________________________

Parent/Guardian Name: ____

Parent/Guardian contact number(s): ____

Parent/Guardian Address: ____

❒ *I understand that it is my responsibility to submit a new form annually or if medical changes occur.*

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PART II: To be completed by Physician (complete sections 1-4):

1) MEDICAL CONDITIONS (check all that apply and list specific food items):

❒ Food **Intolerance**

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Acceptable Substitutions: ____________________

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❒ Asthma *(high risk for severe reaction)*

❒ Food **Allergy** with risk of anaphylaxis

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Acceptable Substitutions: ____________________

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❒ Other Medical Concerns: ____________________

2) SYMPTOMS - Check appropriate action/medication for each category of symptoms:

Type of Symptom	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 extremeties	❒ Epinephrine	❒ Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	❒ Epinephrine	❒ Antihistamine
Throat*: Tightening of throat, hoarseness, hacking cough	❒ Epinephrine	❒ Antihistamine
Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness	❒ Epinephrine	❒ Antihistamine
Lung*: Shortness of breath, repetitive coughing, wheezing	❒ Epinephrine	❒ Antihistamine
Other*:	❒ Epinephrine	❒ Antihistamine
If reaction is progressing (several of the above areas affected), give:	❒ Epinephrine	❒ Antihistamine

* *Potentially life threatening*

3) WHAT TO DO: Follow the directed medication and dosage prescribed by physician.

a) INJECT EPINEPHRINE IN THIGH USING: ❒ Epipen Jr (0.15 mg) ❒ Epipen (0.3 mg)
b) Antihistamine (include medication dose):________________________________
c) Other: give____
d) CALL 911 or RESCUE SQUAD (BEFORE CALLING CONTACTS)
e) CONTACT FAMILY EMERGENCY NUMBERS
f) COMMENTS/ADDITIONAL INSTRUCTIONS

4) *I certify that the above named child needs special meals prepared as described above because of the child's disability / diagnosis. Only a physician licensed under SDCL 36-4 may sign the special diet prescription.*

Physician Name (please print) ____________________________ **Date:** ____________

Physician signature: ____

Medical Facility ______________________________ **Phone:** ______________

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