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. I acknowledge SFCS personnel have limited or no knowledge of administering health services, and it assumes no liability for administering health related services.*

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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
____
____
____

Acceptable Substitutions: ____________________
____
____
____

☐ Food Allergy with risk of anaphylaxis
____
____
____

Acceptable Substitutions: ____________________
____
____
____

☐ Asthma ***(high risk for severe reaction)***

☐ 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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