



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.

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:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth: Itching, tingling, or swelling of lips tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin: Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat*: Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart*: Weak or thread pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung*: Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other*:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> 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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