Aldine Independent School District
Child Nutrition Services

PHYSICIAN REQUEST FOR SPECIAL DIETARY ACCOMMODATIONS

ALL FOOD ALLERGY ACCOMODATIONS MUST BE ACCOMPANIED BY A COMPLETED FOOD ALLERGY ACTION PLAN AND EMERGENCY MEDICATIONS MUST BE BROUGHT TO THE SCHOOL NURSE IN THE ORIGINAL CONTAINERS BY A PARENT OR GUARDIAN.

Please print clearly

Student's Name:		**School:**
Student ID #:		**Date of Birth:**
Medical Condition: ______________________________		
Foods to be omitted *(check all that apply)*		
Milk ________________		All dairy products ________________
All foods containing milk protein (casein, whey, lactose, etc.) ________________		
Wheat ________________	Corn ________________	Seafood ________________
Peanuts ________________	All Nuts ________________	Gluten ________________
Eggs ________________	All Egg Protein (albumin, etc.) ________________	
All products "produced in a facility that also produces nut-containing products" ______________		
__________ Other *(please be specific)* ______________________________		
Foods to be substituted *(if required)* ______________________________		

____
Physician's Signature

____
Date

____
Print Physician's Name

____
Telephone Number *(area code)*

Date request received by Child Nutrition Services: ______________

It is recommended that physician requests be renewed at the beginning of each school year.
Any change of treatment must be requested in writing by the physician.

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Food Allergy Action Plan

Student's Name:_______________________________**D.O.B:**____________**Teacher:**___________________

ALLERGY TO:____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		Give Checked Medication**:	
If a food allergen has been ingested, but *no symptoms*:		☐ EpiPen	☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
Throat	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
Lung	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
Heart	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
Other	____	☐ EpiPen	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

The severity of symptoms can quickly change. t Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give____
medication/dose/route

Other: give____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: ______________________) . State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Call Dr. ____________________________at _________________________________

3. Emergency contacts:

Name/Relationship Phone Number(s)

a. ____ 1.)______________________ 2.) ____________________

b. ____ 1.)______________________ 2.) ____________________

Parent/Guardian Signature____ Date______________

Doctor's Signature____ Date______________

School Nurse Signature____