Food Allergy Action Plan

New Kent County Public Schools

Questionnaire/ Permission Form

JHCF-R2 (Form 2)

Student: _____ Date of Birth: _____

School: _____ Homeroom Teacher: _____ Grade: _____

Contact Information (To be completed by Parent/ Guardian):		
Parent/ Guardian Name #1:		
Address:		
Telephone (Home):	Work:	Cell:
Parent/ Guardian Name #2:		
Address:		
Telephone (Home):	Work:	Cell:
Emergency Contact Name and Relationship:		
Address:		
Telephone (Home):	Work	Cell:
Physician treating severe allergy:		**Office:**

Please answer the following questions :	
1. What is your child allergic to?	
2. What age was your child when diagnosed?	
3. Has your child ever had a life-threatening reaction?	☐ Yes ☐ No
4. What is your child's typical allergic reaction?	
5. Does your child have asthma?	☐ Yes ☐ No
6. Does your child know what food/ allergens to avoid?	☐ Yes ☐ No
7. Does your child recognize symptoms of his/ her allergic reaction?	☐ Yes ☐ No
8. Will you be providing meals and snacks for your child at school?	☐ Yes ☐ No
9. Will your child always eat the school provided breakfast and/ or lunch?	☐ Yes ☐ No
10. How does your child travel to school?	☐ Bus # _____ ☐ Car ☐ Walk

I give permission to the school nurse and designated school personnel to perform and carry out the tasks outlined in my child's Food Allergy Action Plan as ordered by the physician. I understand that I am to provide all supplies necessary for the treatment of my child's allergy at school. I also consent to release of information contained in this plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent's Name: _____

Parent's Signature: _____ Date: _____

School Nurse's Name: _____

School Nurse's Signature: _____ Date: _____