

Food Allergy Form



Student Name:

Attach Photo

Age

Birth date

Student's Parent or Guardian Name

Parent or Guardian Name

Relationship to Student

Parent's Contact No.

Email

FOOD ALLERGY/INTOLERANCES

Food Allergy

Anaphylactic YES NO

EpiPen- Self carry **In Nurse Clinic**

Intolerances

Please specify

Other special diet needs or restrictions

Dietary Needs Questionnaire

Please answer the following questions to better help us with your students needs:

What are the preferred food substitutions, if any?

What types of contact will cause a reaction?

Please explain

Does the Student understand the food allergy and what needs to be done to manage it?

By signing this I am certifying that I understand the disclaimers contained in the form and I verify the information provided is true and correct.

Parent/Guardian Signature
