TRIAD LOCAL SCHOOLS
FOOD ALLERGY ALERT

PARENT: THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WITH A MEDICALLY DOCUMENTED FOOD ALLERGY.

Name of Student: ______________________ Date of Birth: ______________ Grade: ______

Address: ____

Street Address City State Zip

A. I am alerting the school that the student named above has a severe food allergy. This child is allergic to the following foods:

- ☐ Egg
- ☐ Fish
- ☐ Milk
- ☐ Tree Nuts, which include but are not limited to: walnut, almond, hazelnut, coconut, cashew, pistachio, and Brazil nuts.
- ☐ Peanut
- ☐ Seeds: Sesame, sunflower, poppy, etc
- ☐ Shellfish
- ☐ Soy
- ☐ Wheat
- ☐ Other (Specify): ______________________

B. Allergy symptoms associated with the list above. Symptoms usually appear within ________ minutes.

- ☐ Skin – Hives, itchy rash, swelling of the face or extremities
- ☐ Abdomen – Nausea, abdominal cramps, vomiting, diarrhea
- ☐ Throat – Hacking cough, tightening of throat, hoarseness
- ☐ Mouth – Itching, tingling, or swelling of lips, tongue, mouth
- ☐ Lung – Shortness of breath, repetitive cough, wheezing
- ☐ Heart – Thready pulse, low blood pressure, fainting, pale, blueness
- ☐ Mental – Sudden quietness or decreased responsiveness
- ☐ Other: ______________________

C. Emergency action to be taken if allergen is ingested:

- ☐ Administer prescribed medication as indicated below from designated school personnel.
- ☐ Allow student to self-administer the prescribed medication in which should be in his/her possession.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

D. I release and agree to hold the Triad Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent ______________________________ Date: ______________

Parent, guardian or other person having care or charge of the student:

Parent DAYTIME Telephone: ______________________ Work Telephone: ______________________

Other Emergency Contact Name: ______________ Relationship: ______________________

Emergency Contact's Telephone: ______________________ Other: ______________________

LICENSED PRESCRIBER: **TRIAD SCHOOL DISTRICT REQUIRES THAT ALL OF THE FOLLOWING INFORMATION BE PROVIDED BEFORE FOOD SUBSTITUTIONS CAN BE OFFERED, OR SCHOOL PERSONNEL MAY ADMISTER MEDICATION 0R TREATMENT TO THE ABOVE NAMED STUDENT. A COPY OF THIS COMPLETED FORM WILL BE KEPT ON FILE BY THE CAFETERIA SUPERVISOR.**

Licensed Prescriber's statement: I am a licensed health professional authorized to prescribe drugs, and I have prescribed the following emergency medication to the above named student

Student has been trained on the proper use of epi-pen. ____ Yes ____ No Student is capable of possessing and using epi-pen. ____ Yes ____ No

The medication should be used in the following circumstances: ______________________

Report the following severe adverse reactions to my office immediately: ______________________

Procedure to follow in the event that medication does not produce the expected relief of student's allergic reaction: ______________

Prescriber's Signature ______________________________ Office Telephone: ______________

Printed/Typed Name ______________________________ Date: ______________

PARENT/GUARDIAN MUST ACKNOWLEDGE ONE OF THE FOLLOWING (PLEASE INITIAL):

The principal or school nurse has been provided with a back-up dose of the student's medication: ______ Yes ______ No

PRINCIPAL OR NURSE MUST ACKNOWLEDGE ONE OF THE FOLLOWING (PLEASE INITIAL):

I have received a back-up dose of the student's medication. ______ Yes ______ No

Copies must be provided to building principal, the school nurse and the cafeteria supervisor.