HAYWOOD COUNTY SCHOOLS
INDIVIDUALIZED HEALTH CARE PLAN FOR FOOD ALLERGIES
DECLINATION FORM

I, _____, as parent/guardian of

_____

DO NOT wish to have an INDIVIDUALIZED FOOD ALLERGY HEALTH CARE PLAN in place for my child.

I do not feel that an Individualized Health Care plan is needed for my child at this time.

I understand that my child will have an Emergency Action Plan (EAP) in place for life threatening food allergy and I have provided appropriate documentation and medication for my child in the event of a life threatening allergic reaction. I understand that my child will be treated in an emergency situation according to the EAP and that I will be contacted in a timely manner. I have provided the school with current phone numbers where I can be reached at all times. I understand that I may rescind this document at any time and request the formation of an Individualized Food Allergy Health Care Plan.

_____	_____
Signature of Parent	Date
_____	_____
Signature of School Administrator	Date Received
_____	_____
Signature of School Nurse	Date Reviewed