Parent Request for Individualized Food Allergy Health Care Plan
_____School

Student: _____ Grade: _____ Birthdate:_____

Parent/Guardian: _____

Address: _____

Telephone: H ( ) _____W ( ) _____Cell ( ) _____

I hereby request that an Individualized Food Allergy Health Care Plan be developed and implemented for my child. I authorize the institution listed above to secure any related health care information from the health provider listed below. I understand that I must provide medical documentation by a health care provider and appropriately trained staff will need to be in place prior to my child receiving medical services, other than self care, parent care, and Emergency Medical Services (911) at school. This plan will require annual review and updates, as medical care needs change. I also agree to provide the school with:

- **Completed and signed medication forms and current doctor's orders for treatment of allergic reaction**
- **List of allergens that will cause life threatening allergic reaction**
- **Current phone numbers for all emergency contacts**
- **Emergency medication required for treatment of severe/life threatening allergic reaction**

_____ _____
Signature of Parent or Guardian Date

Health Care Provider Information

Current Physician or Health Care Provider: _____

Address: _____

Telephone and Fax Numbers: _____FAX_____

Dear_____: Date: _____

Your request for the development and implementation of an Individual Health Care Plan for Food Allergies for:

_____ (Student Name) has been received. If you have questions,

please contact _____, School Nurse @ _____.

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